

AUTUMN 2004

Harvard Medical

ALUMNI BULLETIN



WHAT HAPPENS WHEN DOCTORS
START TO FEEL FUNNY?



CHAMPION

1959

Overcoming a childhood bout of polio, Tenley Albright '61 captured figure skating gold at the 1956 Winter Olympics, the first American woman to do so. Within a year of her triumph, Albright retired from the sport, turning down lucrative offers to skate professionally—and such dangled perks as a shiny white Cadillac. Instead Albright chose to enter HMS and, like her father, Hollis Albright '31, pursue a career in surgery. She is pictured here as a second-year medical student en route to Europe on the *Queen Elizabeth*.

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In This Issue

FOR YEARS I'D BEEN PESTERING ALUMNI TO TELL ME FUNNY MEDICAL STORIES. "One comes to mind immediately!" a physician of international renown exclaimed, his eyes lighting up. "I was an intern at the House of the Good Samaritan, where we treated children with rheumatic fever. A distinguished professor in a bowtie was leaning over a toddler's bed when the little boy suddenly sat up and spat in the doctor's face."

I nodded encouragingly, awaiting the punchline.

"Of course," the physician said, looking off into the distance, "the child did die two weeks later." He paused, and his voice grew faint. "Well, we all thought it was hilarious at the time."

Suddenly I understood why our special report on humor in medicine was taking so long to produce: not only are physicians' memorable stories too often tinged with tragedy, but what seems comic in the moment can prove maddeningly elusive in the retelling. Other clues began accruing: a psychiatrist drafting a humor essay kept finding his jokes dying on the page. "Eek, I've let you down!" bemoaned an internist. "When I wrote out my experiences, they didn't seem funny after all." Clearly the *Bulletin* was being seized by a you-had-to-have-been-there paralysis of wit.

Perri Klass '86 had warned me that medical training can warp one's sense of humor. But I knew doctors could be funny. Even so, after more than a year of granting requests for deadline extensions for our humor issue, I despaired of being able to feature alumni voices in the *Bulletin's* pages. And I found myself tempted by *The New Yorker* cartoons available for reprinting ("So, could we have all your stuff after you die?" a physician asks his patient in a panel titled "Doctors Without Boundaries") and the bloopers found in doctors' dictations, as captured in *The Bride of Anguished English* ("The baby was delivered, the cord clamped and cut and handed to the pediatrician, who breathed and cried immediately").

But a final shard of understanding kept us from giving up on our alumni. We had considered approaching Conan O'Brien, best known in Harvard Medical School circles as the son of microbiology professor Thomas O'Brien '54. Would the father mind our asking the son to write something witty for us? "Not at all," the good doctor replied, "only I doubt he'll have the time; it's tough coming up with enough material for his show."

If the humor professionals were struggling, then we could certainly grant our alumni more time. And the stories finally came trickling in: medical students fainting at the sight of blood, young Harvard men dashing home in quickly disintegrating seersucker suits, patients lifting up their shirts to reveal abominable abdominal art. At last we needn't have been there to recognize humor in those stories.

Paula Brewer

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Table Manners

I was especially interested in the contents of the Spring 2004 edition, as it stirred up so many memories. For starters, I took the Course in Aseptic Technique, also known as dog surgery, supervised by Carl Walter '32. I had enjoyed the definitive nature of surgical decisions and was strongly considering a surgical career. But that course changed my plans. One factor was that my mind seemed more agile than my hands; another was that it was rumored that Dr. Walter would kick your hand if it strayed below the plane of the operating table, then he'd make you rescrub. I figured if that happened to me, I might be tempted to grab his foot and toss him on his rear. I somehow sensed that such a response might end my career, so I dropped the idea of pursuing surgery.

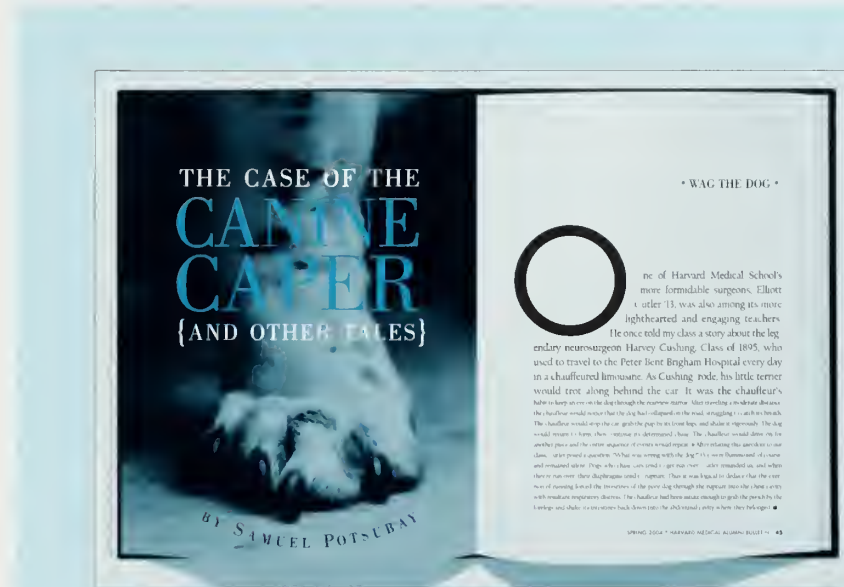
The second story that evoked strong emotion in me was the anecdote Samuel Potsubay '40 told about noticing a thyroid disorder in a friend's wife. I was a medical intern at the Peter Bent Brigham Hospital, where we ate with the nurses in the evenings. I was gazing at a lovely student nurse from Children's Hospital when I noticed a prominence of her thyroid. In my best professional manner, I asked her if I could palpate it. She blushed prettily, and agreed. That same woman, Ellie, and I recently celebrated our 50th wedding anniversary! I believe that was the first and last time that ploy was used. (Incidentally, she did have a goiter that resolved on thyroid supplement.)

Thanks for the memories.

WARREN GUNTHEROTH '52
SEATTLE, WASHINGTON

Joint Returns

I was sad to read of the demise of the Harvard Surgical Research Laboratory in your recent article "Joint Ventures." I underwent the Carl Walter '32 scrutiny there as a medical student, returned to help teach that course in surgical tech-



The pedestrian's fractured tibia was sticking out through his torn trousers and being pulled through the mud. "Here, stop that, put him down!" Cutler cried to the driver who was dragging the pedestrian. But the man only snarled, "Quiet, you fool, I'm a doctor!"

nique for a brief time, then had the opportunity to clone the course at UCLA. Graduates of UCLA from 50 years ago still remind me of the lamp-black and oil routine!

In "The Case of the Canine Caper and Other Tales," by Samuel Potsubay '40, the story Elliott Cutler '13 told about Harvey Cushing's terrier brought back memories of other Cutler narratives. We were in medical school during the beginning of World War II, and civil defense and the care of civilian casualties were hot topics. To spice up those subjects Cutler told us two stories along the lines of "splint 'em where they lie."

In one, he had been driving to the Peter Bent Brigham Hospital on a snowy

day when he saw the car ahead of him go into a skid and pick off an unlucky pedestrian. Cutler stopped and rushed over in time to see the driver grab the pedestrian under the arms and start dragging him toward his car. Cutler could see the pedestrian's fractured tibia sticking out through his torn trousers and being pulled through the mud. "Here, stop that, put him down!" Cutler cried. But the driver of the other car only snarled, "Quiet, you fool, I'm a doctor!"

The second Cutler story—more likely a fabrication—concerned two motorcyclists who had been headed out on the Jamaica Way in Boston on a cold and windy fall day. Their jackets were catching the cold air gusts, so they stopped to



LEGENDS OF THE SPRING

The Spring 2004 issue of the *Bulletin* was outstanding, from the Navajo articles to all of the stories about Drs. Cutler and Cushing, who gave our class memorable lectures and had us standing shoulder-to-shoulder with Edward Churchill, Class of 1920, as second and third assistants. This edition was easily on par with your 75th anniversary issue.

DONALD BICKLEY '34
WATERLOO, IOWA

put their jackets on backward. As they pulled back into traffic, a truck hit them. The police officer reporting the incident wrote: "One of them was dead when I got there, and by the time I got the other's head turned around the right way, he was dead, too."

I was in the last group of Brigham interns that Cutler chose, and, I believe, the last Cabot Fellow he appointed. My year in the lab was shared with future stars—Felix Eastcott of London, known later for one of the earliest carotid artery reconstructions, and Eric Rogers of Canada. David Hume was then deep into the study of the hypothalamus of hibernating animals, and there was the wonderful Charlie Hufnagel '41 of the first aortic valve. Hufnagel was surely one of the most dexterous and innovative surgeons I have ever met; sadly he was so modest he let many of his innovations pass into the surgical armamentarium without getting his name associated with them.

And, of course, hovering over us all was Carl Walter. I don't believe I ever did an operation later on without using something Carl taught me about surgical technique, nor did I ever watch another surgeon without thinking, "You could do it more easily if you followed Carl's techniques!" I never uttered those words out loud, however.

My year in the laboratory came under the tenure of Francis Moore '39, who had succeeded Cutler while I had been in the Navy. That year was dedicated to the pancreas, especially studies of the accumulation of fat in the liver when the animal was deprived of some factor in the pancreas.

What did stand me in good stead a few years later were the exercises Charlie Hufnagel urged on me, repeating as many of Alexis Carrel's vascular surgical procedures as I could fit into the schedule.

WILEY F. BARKER '44
AGOURA, CALIFORNIA

Contractual Difficulties

I found the article "Joint Ventures" in the spring issue of the *Bulletin* fascinating. It brought back my fondest days at the Medical School.

As part of my training, Elliott Cutler '13 appointed me to the Arthur Tracy Cabot Fellowship and I spent more than a year in the Surgical Research Laboratory. One of my projects involved a study of peristalsis. In 1945, when I had been chief surgical resident for one year, William Ladd invited me to join the Children's Hospital staff.

I spent a good deal of my time in the outpatient clinic and became interested in several desperately ill children with

Hirschsprung's disease. I consulted Dr. Ladd and learned that he had tried all available treatments in vain. The patients were barely kept alive with frequent washout.

One morning on rounds I was surprised to find the massive distention in one of these patients, who during the night had received a sigmoid colostomy, beginning to recede. By the next day his abdomen was concave, as if a mechanical obstruction had been relieved. But this was impossible, for an earlier sigmoidoscopic examination had revealed no obstruction. I immediately determined to test the colon proximal to the colostomy for peristalsis and was stunned to record normal function. It is, after all, the absence of peristalsis that prevents the intestinal system from functioning in patients with this curious, fatal disease.

When I recorded distal to the colostomy I discovered that there was no peristalsis. Thus, the area of colon that appeared to be diseased was not; the problem lay not in the dilated segment of colon but in the seemingly normal area of the sigmoid and rectum. The last study of our results in treating this fatal disease by removing the entire obstructive lesion is composed of 880 patients followed for up to 40 years, and 96 percent are healthy with normal intestinal function.

ORVAR SWENSON '37
CHARLESTON, SOUTH CAROLINA

Unconventional Wisdom

I wanted to comment on the quality of the Spring 2004 issue of the *Bulletin*. My wife and I were both struck by the number of very interesting articles and the attractive layout. I was particularly drawn to the report on G. Robert DeLong's work on iodine deficiency and cretinism, which I had not realized to be such an international problem still. Long ago, I knew Bob at Massachusetts General Hospital, where he was the first to teach me about bipolar

disorder in children and one of the first to use lithium for its treatment in children. Many years later, I have come to understand the importance of that work and the continuing reluctance of many child psychiatrists to accept the proposition that even prepubertal children can experience something like mania and major depression.

ROSS BALDESSARINI, DSC, MD
BELMONT, MASSACHUSETTS

Dynamic Dynasty

I thought my fellow alumni would be interested in knowing that when Michael Frank '60 stepped down from the chairmanship of the Department of Pediatrics at Duke University in March 2004, we ended 50 consecutive years of successful leadership of our department by alumni of HMS. Jerome Harris '33 served as chairman from 1954 to 1969, Samuel Katz '52 from 1969 to 1990, and Mike from 1990 to 2004. Each chairman more than met the particular challenges of his times, and together they helped to make our department one of the finest in the country.

In his "retirement," Mike is following in the tradition of his predecessors by entering another productive phase of his career, in his case by returning to his laboratory to study complement. Sam is an important advocate for rational immunization policies in the United States and abroad, and Jerry served as chairman of the Institutional Review Board for many years after stepping down as department chairman. It has been my privilege to work with these fine colleagues for the past 25 years.

GORDON WORLEY '73
DURHAM, NORTH CAROLINA

The Bulletin welcomes letters to the editor. Please send letters by mail (Harvard Medical Alumni Bulletin, 25 Shattuck Street, Boston, Massachusetts 02115); fax (617-384 8901); or email (bulletin@hms.harvard.edu). Letters may be edited for length or clarity.

SHARING THE MINERAL WEALTH

SOON AFTER THE SPRING 2004 ISSUE OF THE *BULLETIN* APPEARED, G. Robert DeLong '61 received an email from Tim Wallace, a Peace Corps worker in Kokand, Uzbekistan. Wallace had read the *Bulletin's* cover story, which featured DeLong's efforts to find innovative ways to introduce iodine to regions that have been both tragically deficient in the precious mineral and resistant to conventional delivery methods.

"I work with a local association of endocrinologists who are trying to reduce the level of endocrine diseases here," Wallace wrote. "Because of iodine deficiency, the rate of goiter is approximately 80 percent for the area and as high as 99 percent in some rural areas. The organization worked on a project to fortify bread with iodine, but it wasn't sustainable. Another organization tried promoting iodized salt several years ago, but that also failed. I was hoping you might be able to provide us with some guidance."

Two months later, DeLong visited Uzbekistan, where he met with Wallace and more than 80 physicians and other health care workers. They have since developed a proposal and hope to start, in the spring of 2005, a pilot project of dripping iodine into irrigation water in the Ferghana Valley, in an area with a population of 12,000. "One never knows the reach of one's work," DeLong says. "Many thanks to the *Bulletin*."



PHOTO: SHANNON HADLER



HEAD OF THE CLASS: This rare nineteenth-century Beauchene or "exploded" skull of real bone was constructed for anatomical studies; today such teaching tools are made of plastic.

Body of Knowledge

THERE WAS NO COUGHING UP THIS hairball; removed from the stomach of a 50-year-old woman, it approximates a football in size, shape, and color. The patient had been employed at a wig factory, and her doctor hypothesized that over the years she had inhaled the hair. Donated in 1933, the hairball is one of thousands of items belonging to the Warren Anatomical Museum, which helped generations of Harvard medical students learn their art.

The hairball now forms part of a collection of specimens assembled by Warren Museum archivists at the request of Kitt Shaffer, an associate professor of radiology at HMS, for her Human Body class. In addition to the hairball, the Human Body exhibit includes a preparation of tattooed skin that illustrates two American flags flanking a memorial stone; golfball-sized bladder calculi; a portion of an articulated skeleton; and a nineteenth-century preparation show-

ing an arm complete with arteries, veins, and nerves. To prepare this last specimen, some skin was removed from the arm so that the arteries and veins could be injected with hot wax. When the wax dried, the tissue was cut away, creating a wax model of the arteries and veins before the whole specimen was dried and then covered with a material similar to varnish.

The exhibit also contains a pelvis with a right femur and dislocated left femur attached, a specimen commonly referred to as the "Lowell hip." A prominent New Englander who had dislocated his hip in a fall from a horse, Lowell was dissatisfied with the final result after treatment. Although he had not heeded his doctor's advice, he sued. His specimen later became associated with one of the earliest medical malpractice cases to go to court. The court eventually ruled in favor of Lowell's doctors. When Lowell died, the Warren Museum's founder, John Collins Warren, who had served as a wit-

The State of the School

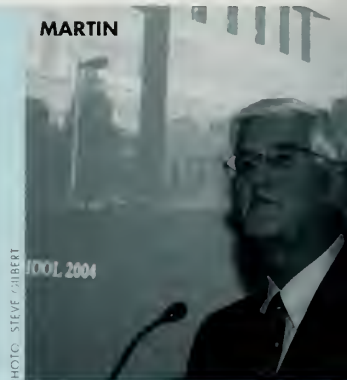
IN HIS SEVENTH ANNUAL STATE OF THE SCHOOL ADDRESS, HMS DEAN Joseph Martin used a quotation from Ralph Waldo Emerson to define the institution's progress over the past year: "Do not go where the path may lead. Go instead where there is no path and leave a trail."

Among the trailblazing efforts that have taken place at the Schaal during the past year, Martin highlighted the AIDS activities conducted by the faculty. "If one looks at the work that we are doing around the world, there is probably no focus more important than that involving AIDS," he said. Martin highlighted the Vietnam-CDC-Harvard AIDS Partnership, developed and directed by Eric Krakauer, an HMS instructor in social medicine. In just a few years, the program has trained more than 300 Vietnamese doctors. Martin also cited Harvard Med-

ical International, which supports AIDS education programs in India, China, and other countries.

"It has been truly remarkable how many things have happened just in the last 12 months," Martin said, referring to the HMS research enter-

prise. He pointed to the expansion of investigations in the New Research Building on the North Quad, which has freed up laboratory space on the South Quad. And he commented on several faculty collaborations, including one in which a combination of clinically trained and basic science trained people are



ness in the case, autopsied the body and donated the pelvis to the museum.

Perhaps one of the most mysterious specimens on display is a collection of skeletal remains sent to the Warren Museum in 2000 by the coroner's office of Los Angeles County. Two wooden boxes were recovered from a dumpster in East Los Angeles. Within one of the boxes was a card indicating that the contents belonged to HMS.

According to the anthropologist's report that accompanied the boxes, the contents included a cranium and various other human bones. All of the bones were bleached, and the top of the skull had been removed by a high-speed saw and then re-attached with brass fittings. The report concluded that the remains had no forensic value and had likely been intended for educational purposes.

So how did they find their way into an East Los Angeles dumpster? The inventory card in one box stated not only that the contents were the proper-

ty of HMS, but that the student borrowing the box must return it when it was called for and would be charged for any loss or breakage. Remarkably, according to the inventory, the contents of both boxes were intact and in good condition—quite impressive considering the last sign-out date on the card was 1952.

During the nineteenth and early twentieth centuries, the Warren Museum became one of the country's leading medical museums. The collection began in 1800 with a gift from John Collins Warren, the first to hold the title of dean of HMS. Not only did Warren donate the anatomical specimens he had been collecting for years, but he later bequeathed his own skeleton to the museum. Later contributors included two of his descendants—Jonathan Mason Warren, Class of 1832, and John Collins Warren, Class of 1866—and two subsequent deans of HMS—Oliver Wendell Holmes, Class of 1836, and J. B. S. Jackson, the museum's first curator.



CSI: LOS ANGELES: The brass fittings used to reattach the top of a skull convinced the Los Angeles coroner's office that two boxes of bones found in a dumpster were of an academic rather than criminal origin.

And now, some 20 years after the collection was last officially used for pedagogical purposes, HMS students are once again enjoying the learning opportunities that it offers. The exhibit gallery for the museum is located on the fifth floor of the Countway Library; visit www.countway.harvard.edu/warren/index.shtml to learn more. ■

using a proteomic approach to look at the cellular events that lead to neurodegenerative disorders.

Addressing the planning process for the new Allston campus, Martin said, "One of the most important issues we will be facing this academic year is exactly how the Medical School will be engaging in this set of activities without in any way diminishing our strength here by the relocation of programs or activities that would distance us from our students or from our hospitals."

Changes in educational programs, said Martin, were also one of the year's major efforts. Martin acknowledged four new leaders of graduate programs, Robert Kingston, David Knipe, Gory Yellen, and Christopher A. Wolsh. He also discussed reorganizing the Program in Medical Education, with Nancy

Oriol '79 filling the new position of dean for students and Ronald Arky taking the new role of dean for curriculum.

Martin outlined some of the progress of the Medical Education Reform Initiative. He identified the five central challenges as the content of the curriculum, student costs, compassionate and culturally competent care, the compensation of clinical teachers, and the choice of academic health centers. Despite these hurdles, the initiative is on track to roll out the new curriculum in the fall of 2006.

Likewise, Martin said, budgetary challenges face the School in building on the accomplishments of the past year, but the administration is optimistic about eliminating the remaining deficit and continuing on its present course of growth and discovery. ■

Banding Together Against AIDS

MOST OF THE ESTIMATED 14,000 people a day worldwide who become infected with HIV live in nations desperately short on resources. A number of Harvard Medical School researchers have therefore been striving to provide leadership in the struggle against AIDS not only in the United States, but in the developing world as well.

And now the National Institutes of Health has announced that it will fund a new HMS Center for AIDS Research (CFAR) with a total of \$15 million over five years. The award, which reflects an integration of two existing HMS-based CFARs, doubles the CFAR funding cap of \$1.5 million per year.

As principal investigators of the two previous CFAR awards, Bruce Walker, head of the HMS Division of AIDS, and Joseph Sodroski, HMS professor of pathology at the Dana-Farber Cancer Institute, petitioned the National Institutes of Health to raise the cap and make the integration fiscally viable.

"We are excited about this award," Walker says, "and we see the CFAR as



GRIM LEGACY: A South African woman sits surrounded by the grandchildren she adopted after their parents died of AIDS. The children are clutching their parents' death certificates.

a forum where people can come together under a common umbrella to get things done and to try to realize the most synergy possible from the out-

standing components that are already here at Harvard."

"This expanded program is a case," Sodroski adds, "in which the new whole



The Class of 2008

THE NEWEST MEMBERS OF THE HARVARD MEDICAL SCHOOL COMMUNITY—THE CLASS OF 2008—donned their ceremonial white coats in September. The class is 47 percent women and 53 percent men. Twenty-six percent of the students are Asian Americans, 8 percent African Americans, 7 percent Latinos, and 3 percent Native Americans. The class represents 33 states, plus Puerto Rico, and 5 foreign countries: Bulgaria, Canada, India, Sweden, and Yugoslavia.

The youngest entering medical student is 21 years old, the oldest is 29, and the median age is 23. Roughly three-fourths of the class majored in the sciences while undergraduates; 14 percent majored in the social sciences, 5 percent in the humanities, and 9 percent in other majors and/or double majors. ■

TAKING IT TO THE STREETS: A pre-orientation program, the First-year Urban Neighborhaad Campaign, took place in August, introducing 55 members of the Class of 2008 to outreach opportunities in the Boston area.

will be even better than the sum of already excellent parts."

The NIH CFAR program provides administrative and research support to leading AIDS research projects. Twenty centers operate around the country, but Harvard's is the first new center to qualify for increased funding. The Harvard CFAR will revolve around five scientific programs: international, therapeutics, vaccine development, pathogenesis, and epidemiology. The grant also allows support for feasibility studies, up to \$50,000 per year for up to ten projects. "This will provide the necessary infrastructure and funding to explore high risk, high-impact research avenues," Sodroski says.

The announcement of the new grant comes soon after the formation of the Harvard University Program on AIDS (HUPA), which will coordinate AIDS-related programs throughout the University under the umbrella of the Harvard Initiative on Global Health, headed by Paul Farmer '90. "We see the CFAR as a founding program within HUPA that has the potential to bring schools and faculty together around AIDS-related research, whether that's in social sciences, the political arena, legal areas, or any issue that supports the University's efforts to help end the AIDS pandemic," says Tom La Salvia, executive director of the HMS Division of AIDS.

CFAR projects are already having an impact in some regions of the world that are hardest hit and least able to cope with AIDS, including the KwaZulu-Natal province in South Africa, the Eastern Caribbean, and Vietnam.

"Bringing together the efforts of the two CFARs within the Harvard Medical community while embracing complementary efforts across Harvard creates powerful synergies to hasten our efforts to quell the global AIDS crisis," says Joseph Martin, dean of the Medical School. "This is a noteworthy example of the power of combining resources and research endeavors to unite disparate faculty around HMS research priorities." ■



Saluting a Mentor

A NEW FUND HAS BEEN CREATED TO HONOR A FACULTY MEMBER WHO HAS SERVED as a beloved mentor to hundreds of HMS graduates over the past 35 years: Alvin Paussaint, faculty associate dean for student affairs at HMS since 1969, is an expert on race relations in America, the dynamics of prejudice, and issues of diversity. Paussaint is also director of the media center at the Judge Baker Children's Center and a professor of psychiatry at HMS.

From 1965 to 1967, Paussaint was southern field director of the Medical Committee for Human Rights in Jackson, Mississippi, providing medical care to civil rights workers and aiding in the desegregation of health facilities throughout the South. Two years later, HMS recruited him to its faculty in part to help shepherd the School's affirmative action efforts.

When he joined the Harvard Medical School faculty, Paussaint became passionately committed to supporting diversity in the HMS community. It is a goal he has pursued in a variety of administrative roles at the School over the years.

"Harvard Medical School students today not only interact with people from every socioeconomic and cultural background—especially from backgrounds less represented in medicine historically—but also learn a lot from the unique life experiences that their fellow students bring to the School," says Paussaint. "Diversity and diverse collaborations can provide enormous benefits for the way that medicine is practiced in the United States and around the world."

"Alvin Paussaint has been a mentor to thousands of students, residents, fellows, and junior faculty, as well as a trusted peer advisor to senior faculty at Harvard Medical School and across the country for nearly four decades," says Jaan Reede, dean for diversity and community partnership at HMS. "It has been my honor and privilege to work closely with this remarkable man, who has had such a profound impact on medicine, psychiatry, and the image of the African American family in the media."

The Alvin F. Paussaint, MD Visiting Lecture Fund at HMS will bring an underrepresented graduate of the School or its affiliated training programs back to campus each year to give a lecture. The inaugural lecture and a celebration of the new fund will take place at HMS on February 12, 2005. ■

**To learn more
about the inaugural
lecture and
celebration, visit
[www.mfdp.med.
harvard.edu/
celebratepaussaint](http://www.mfdp.med.harvard.edu/celebratepaussaint)
or call
617-432-1133.**

Them and Us

Cult Thinking and the Terrorist Threat

by Arthur J. Deikman '55 (Bay Tree Publishing, 2003)

YEARS AGO, I HAD A FRIEND WHO BELONGED TO A CULT. I got to know him before he joined. Eventually, I did not know him anymore. An exotic, fascinating serpent had swallowed him whole. I gazed from a safe distance, as through a telescope aimed at some evil galaxy.

Cults are places for the fragile and misled. The strong-minded among us know better than to travel there ourselves. Therefore, it would seem implausible, as psychiatrist Arthur Deikman '55 argues in *Them and Us*, that "cult...thinking (is) so pervasive in normal society that almost all of us might be seen as members of invisible cults." The very suggestion threatens proud free will.

But Deikman builds his case inexorably. Politics, religion, education, earnest professional identity, and ordinary social lives are all avenues of cult indoctrination. No one is immune. By the end of his book, you feel the wall against your back.

Here is some of what the author says: we are indoctrinated without consciousness or intent, driven, as Freud once said, by unknown forces. It begins at birth. The most powerful force acts first in childhood, where parents offer absolute security in exchange for absolute dependency. We never lose the yearning to look to someone who can guarantee safe passage through ever-more treacherous waters.

Traditional cults manipulate this "dependency dream" in four ways: creating a leader (who is paternal at first, then autocratic); demanding compliance with the group (given willingly, then in fear); attacking dissent (which is framed in terms of disloyalty); and devaluing outsiders (who quickly become enemies). These were the tactics in Waco and in Guyana and among Tokyo's Aum Shinrikyo. Some see them in today's Islamic extremism, others see them operating behind the Religious Right. As tactics, they are not hard to spot—except when applied to ourselves.

For instance, adherence to a cult leader who suppresses autonomy and demands "obedience and power...over truth and conscience" seems safely inconceivable to a thinking person. But what about CEOs who "inspire rather than overpower"? The religious leader guided by God who "brands disagreement...as a sign that the defiant member is lost to salvation"? The undoubting political leader who creates a "fantasy of

invulnerability" and cites higher principles (including national security) to justify his actions?

Cults allow no alternative views; they "inhibit and stifle disagreement." Of course. But so do corporations, where survival of the business is a religious mission. Deikman describes the disastrous Corvair car, whose design caused it to flip at high speeds. General Motors engineers knew this, but their protests were overruled, catastrophically, by managers.

In medicine, Ignaz Semmelweis, the physician who first warned that high rates of maternal deaths during delivery were caused by obstetricians with unwashed hands, was ridiculed so relentlessly by his peers that he went mad. Politics uses a different, coarser tactic to stifle disagreement: secrecy. Deikman argues that the Allende overthrow in Chile and the Iran-Contra scandal, among others, were engineered covertly to avoid criticism.

But the most ubiquitous everyday cult behavior we practice is devaluing outsiders. Personal identity and moral value increase in direct proportion to the lesser worth of others. This tendency, Deikman writes, "provides a rationale for actions that would

otherwise place us in the bad category." AIDS research, for example, was awarded less initial money than Legionnaire's disease—which killed 29 people—because AIDS was seen as the disease of the sexual outsider. The examples in *Them and Us* multiply miserably and undeniably. This is grim, but not necessarily final.

Deikman has a recommendation: bring unconscious drives into consciousness; begin "the uncomfortable process" of fostering dissent. Dissent and discussion, he contends, may be the only legitimate means to "rescue us from selective blindness."

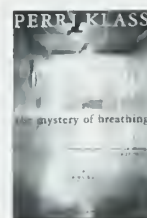
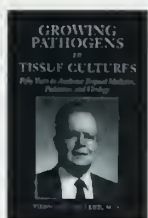
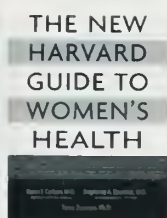
Awareness is a start. But it would require some inconceivable leaps—among them, that enemies acknowledge the flaws and strategies they have in common. "Devaluation reinforces your sense of rightness," the author writes, "and both Osama bin Laden and George W. Bush have made use of this tactic."

A cult, Deikman writes midway through the book, "is something that you yourself don't belong to. One's own group is...above such behavior." Nearly a hundred pages later, his book demolishes that satisfied idea. We gather in groups of sameness. Conflict requires *Them and Us*; we are good only because they are bad. But we have never paid as high a price for our certainty. These are among the most terrifying times in history—not least because America has helped to create them. ■

Elissa Ely '88 is a lecturer on psychiatry at HMS.



THE MADDING CROWD: Members of the Aum Shinrikyo cult—responsible for the deadly release of sarin in the Tokyo subway system in 1995—hold a demonstration clad in masks fashioned in the likeness of their leader.



Trance & Treatment

Clinical Uses of Hypnosis, by Herbert Spiegel and David Spiegel '71 (*American Psychiatric Publishing*, 2004)

This father-son team, both psychiatrists and psychoanalysts, delve into the human capacity for hypnosis and its use in treating patients. They debunk common myths—for instance, that hypnosis is a kind of sleep. Rather, they say, it is more akin to intense concentration. Through examples, the authors discuss how to use the results of the Hypnotic Induction Profile to develop strategies for smoking cessation, pain control, and the treatment of asthma, anxiety, stuttering, and eating disorders, among other problems.

The New Harvard Guide to Women's Health

by Karen J. Carlson '80, Stephanie A. Eisenstat, and Terra Ziporyn (*Harvard University Press*, 2004)

This update of a 1996 edition includes recent advances, reversals, surprises, and challenges in women's health and aims to answer the kinds of questions physicians hear every day. In an A-to-Z format, it lists more than 300 problems or conditions with entries that outline their basic physiology, typical symptoms, evaluation, treatment, and prevention. The authors give the latest recommendations on heart disease, hormone replacement therapy, medications, procedures, screenings, and diagnostic tests.

Growing Pathogens in Tissue Cultures

Fifty Years in Academic Tropical Medicine, Pediatrics, and Virology, by Thomas H. Weller '40 (*Science History Publications*, 2004)

Weller's epidemiological career took off with the research race to discover a polio vaccine and culminated with winning the Nobel Prize. Some of the most enjoyable aspects of this view of a life in science are the many engaging first-person accounts of political, geographical, and scientific challenges. Weller communicates the excitement, heartbreak, and danger of contamination associated with his search for vaccines.

A Write of Strings

Selections from Thirty Years of Chamber Music Notes, by Craig B. Leman '52 (*Chamber Music Corvallis*, 2004)

This carefully researched book collects 200 of Leman's concert notes and essays on some of the world's beloved composers and their finest works. Leman, a pianist and surgeon, peppers his commentary with biographical details and irresistible anecdotes.

Seascapes

by David Sanders Howell '47 (*Howell*, 2004)

Howell's passion for both the sea and painting began in his early adolescence. Since his first art classes, he has stopped neither creating nor sailing, despite the restrictions on his time as internist,

rheumatologist, and professor at the University of Miami School of Medicine. This book's tranquil and thunderous scenes depict the majestic sea in its many moods and lights, from Maine to Miami. Howell chronicles his influences and development as an artist in an opening essay.

Escape Fire

Designs for the Future of Health Care, by Donald M. Berwick '72 (*Jossey Bass*, 2004)

The author offers insights into providing quality care and suggestions for change, using medical and non-medical examples—such as Captain James Cook's insistence on serving his crew sauerkraut to prevent scurvy—for inspiration. Berwick, chief executive officer of the Institute for Healthcare Improvement, delivered these essays as speeches at the National Forums on Quality Improvement in Health Care.

The Mystery of Breathing

A Novel, by Perri Klass '86 (*Houghton Mifflin*, 2004)

Pediatrician and writer Perri Klass combines mystery with medicine in her latest novel. Doctors and lay readers alike will feel at home in the NICU where neonatologist Maggie Claymore devotes her time. She becomes the target of an anonymous smear campaign that plays on the fears of contemporary doctors: liability and malpractice. Klass avoids an easy resolution to the novel's mystery and offers instead a heartbreaking conclusion with a surprising silver lining.



A Laughing Matter

HOW MANY PSYCHOTHERAPISTS does it take to change a light bulb? Only one, but the light bulb has to really want to change.

Once considered taboo, a jocular attitude—and the laughs it can inspire—can increasingly be found not only about the therapeutic encounter, but within it as well. The role laughter plays in psychotherapy has been disputed since the days of Freud. Some early therapists believed that their laughter could wound patients, while more recent thinking has held that, if used nonjudgmentally, laughter can help support the therapeutic partnership. But none of those theories was based on objective data.

In the October issue of *The Journal of Nervous and Mental Disease*, researchers from Massachusetts General Hospital report the first physiologic evidence of the role of laughter during psychotherapy sessions. The investigators found that patients use laughter to communicate emotional intensity to their psychotherapists, much like an exclamation point at the end of a sentence. In addition, patients' and therapists' laughing together magnifies that intensity and may contribute to their rapport.

"Current research on laughter in general shows it is more about communicating emotion than about humor," says Carl Marci '97, director of social neuroscience in the Department of Psychiatry at Massachusetts General Hospital and the paper's lead author. "Many therapists have been caught up in the old notion that laughter signifies only humor, even ridicule, and have questioned whether using laughter in therapy is

appropriate. We wanted to take an objective look at the occurrence of laughter during therapy and measure its physiologic effect."

As part of a larger ongoing study of psychophysiology and empathy, the researchers—including coauthors Erin

Moran and Scott Orr—videotaped therapeutic sessions and took physiologic measurements of both members of ten patient-therapist pairs. The patients were being treated for common mood and anxiety disorders in previously established patient-therapist relationships. Participating therapists practiced psychodynamic therapy, an approach that uses the therapeutic relationship to help patients develop insight into their emotions.

Throughout the therapy sessions, the physiologic responses of both patient and therapist were determined by skin conductance recordings. These recordings are commonly used to measure the activity of the sympathetic nervous system, which controls physiologic arousal and increases such parameters as blood pressure and heart rate. Earlier studies have shown that laughter increases arousal and that elevated skin conductance is associated with increased empathy between therapists and patients. Following the sessions, independent observers reviewed the videotapes and identified each laugh episode according to who was speaking prior to the laughter and whether the other person laughed as well.

In the ten recorded sessions, the observers identified 145 episodes of laughter. On average, patients laughed more than twice as often as therapists did and were most likely to be laughing in response to their own comments. Therapists also were more likely to laugh in response to what patients had said. The skin conductance measurements showed that laughter produced



The researchers found that patients use laughter to communicate emotional intensity to their psychotherapists, much like an exclamation point at the end of a sentence.

Research Digest

physiologic arousal in both patients and therapists, with arousal strongest when both laughed together.

"We were surprised to find how common laughter was in therapy—an average of 15 laughs per 50-minute session," Marci says. "Taken together with the current understanding of laughter outside of psychotherapy, our findings suggest that the patient who is laughing is trying to say more than has been expressed verbally to the therapist. Laughter is an indication that the subject is emotionally charged."

The relatively rare occurrence of laughter among therapists—and the fact that, when they did laugh, it was almost always in response to patient comments—reflects the focus of therapy on the patient's emotions, Marci says. He also notes that the therapists showed a physiologic reaction to their patients' laughter even when not laughing themselves, indicating an empathic response to their patients. When the therapists did laugh, the patients' physiologic responses went even higher, supporting the well-known notion of the contagiousness of laughter and suggesting that, when therapists laugh with patients, the patients feel validation of the emotions they are expressing.

"The clinical implications of the findings support the need for therapists to pay closer attention to when patients laugh during psychotherapy," Marci says. "Therapists should explore the meaning of what is said immediately preceding the laughter."

The researchers' next step is a longer-term study that examines how the occurrence of laughter evolves as the therapeutic relationship develops, with the ultimate goal of finding any significant relationship between laughter and improved mental health for patients. In the meantime, jokes about the therapeutic relationship will surely continue. ■

DAMAGE PATROL

The ungainly movements, dementia, and mood swings that characterize Huntington's disease result from a single mutation that kills neurons in a specific brain structure, the striatum. It now appears that this mutation triggers defects in other areas of the brain, and even in other parts of the body, yet these other cells somehow manage to survive. These findings are described by Ole Isacson, an HMS professor of neurology, and colleagues in the September *Annals of Neurology*. Isacson and his team are now turning to new experiments that will try to elucidate cellular defense mechanisms. Their research may also increase understanding of other types of adult-onset neurodegenerative diseases, such as Parkinson's disease, amyotrophic lateral sclerosis, and Alzheimer's disease.

WOMAN WONDER

A study by researchers at Beth Israel Deaconess Medical Center of amenorrheic women described in the September 2 issue of the *New England Journal of Medicine* shows that low doses of leptin resulted in restored ovulation for some patients, increased levels of reproductive and neuroendocrine hormones, and hinted at better bone formation. The findings have implications for very thin women who are dealing with problems of infertility, competitive athletes and dancers whose thin frames put them at risk for bone fractures and osteoporosis, and women battling eating disorders, such as anorexia nervosa, says Christos Mantzoros, HMS associate professor of medicine.

THIN RED LINE

The largest clinical study of its kind shows that almost half of the complications and deaths due to in-hospital deep vein thrombosis (DVT) could be prevented with a daily administration of the blood-thinner dalteparin, according to results published in the August 17 issue of *Circulation*. DVT occurs in approximately two million people a year, more than 600,000 of whom are at risk of a blood clot migrating to the lungs and blocking the pulmonary artery. Pulmonary embolism is the third leading cause of death in the United States. According to Samuel Goldhaber, the study's senior investigator and an HMS associate professor of medicine at Brigham and Women's Hospital, "Patients who fit the profile—including those with cancer, or respiratory and congestive heart failure—should be considered at risk for DVT or a pulmonary embolism and be closely monitored."

HITTING THE SNOOZE ALARM

A study in the September 27 issue of the *Archives of Internal Medicine* found that among people with chronic insomnia, advice from a therapist is more likely to produce a normal night's rest than Ambien, the top-selling sleep aid, whose sales reached \$1.5 billion in 2003. Sleeping pills should be prescribed mainly for people whose insomnia is caused by an event or illness, such as jet lag or the side effects of chemotherapy, according to the lead author of the study, Gregg Jacobs, an insomnia specialist at the Sleep Disorders Center at Beth Israel Deaconess Medical Center and assistant professor of psychiatry at HMS. Other insomniacs, Jacobs adds, are staying awake in part because of bad sleep habits that a behavior therapist can help change.



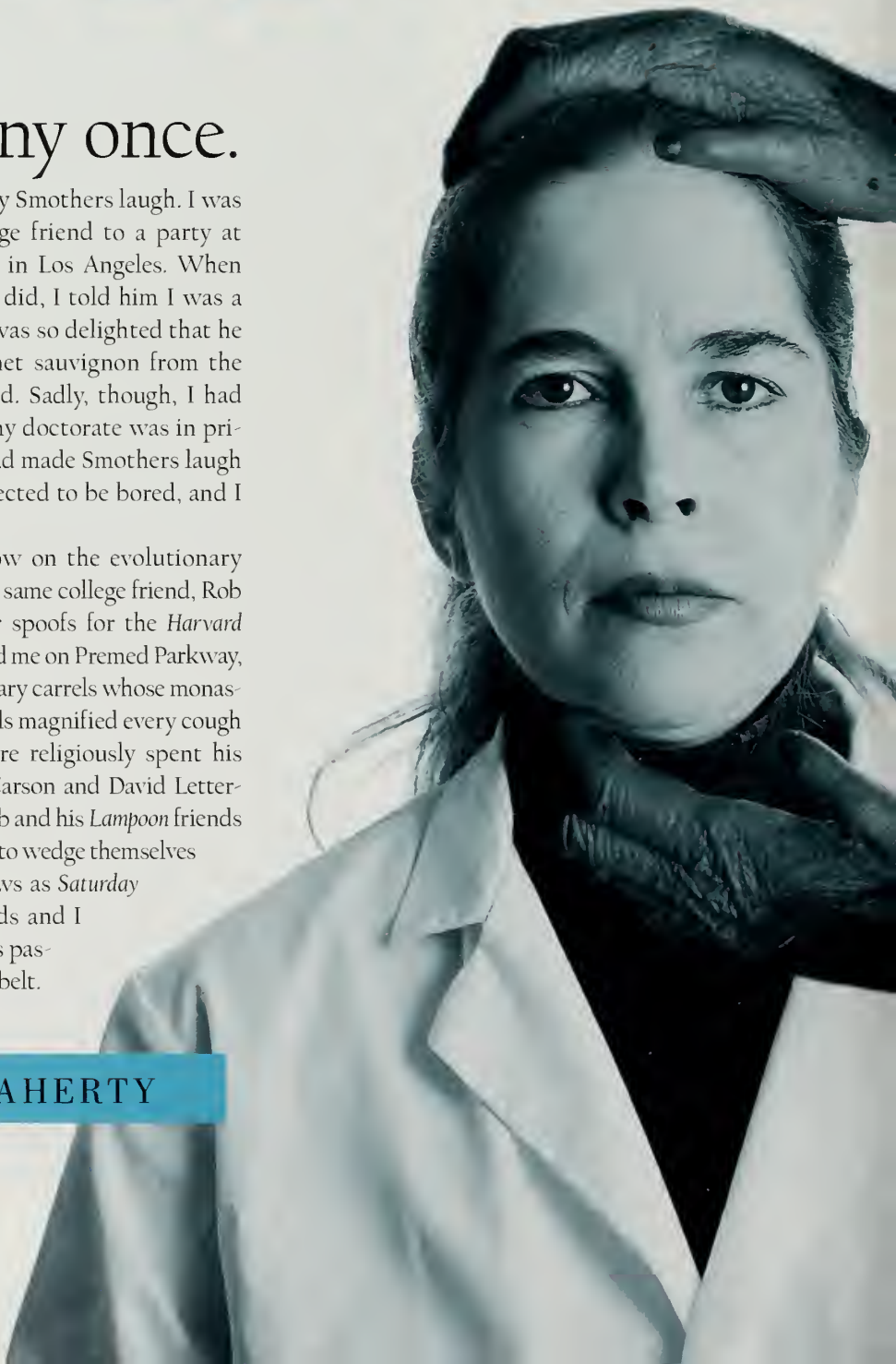
MONKEY

I was funny once.

At least, I once made Tommy Smothers laugh. I was tagging along with a college friend to a party at the great comedian's house in Los Angeles. When Smothers asked me what I did, I told him I was a monkey vivisectionist. He was so delighted that he gave me a bottle of cabernet sauvignon from the Smothers Brothers Vineyard. Sadly, though, I had not intended to be funny: my doctorate was in primate electrophysiology. I had made Smothers laugh merely because he had expected to be bored, and I had caught him by surprise.

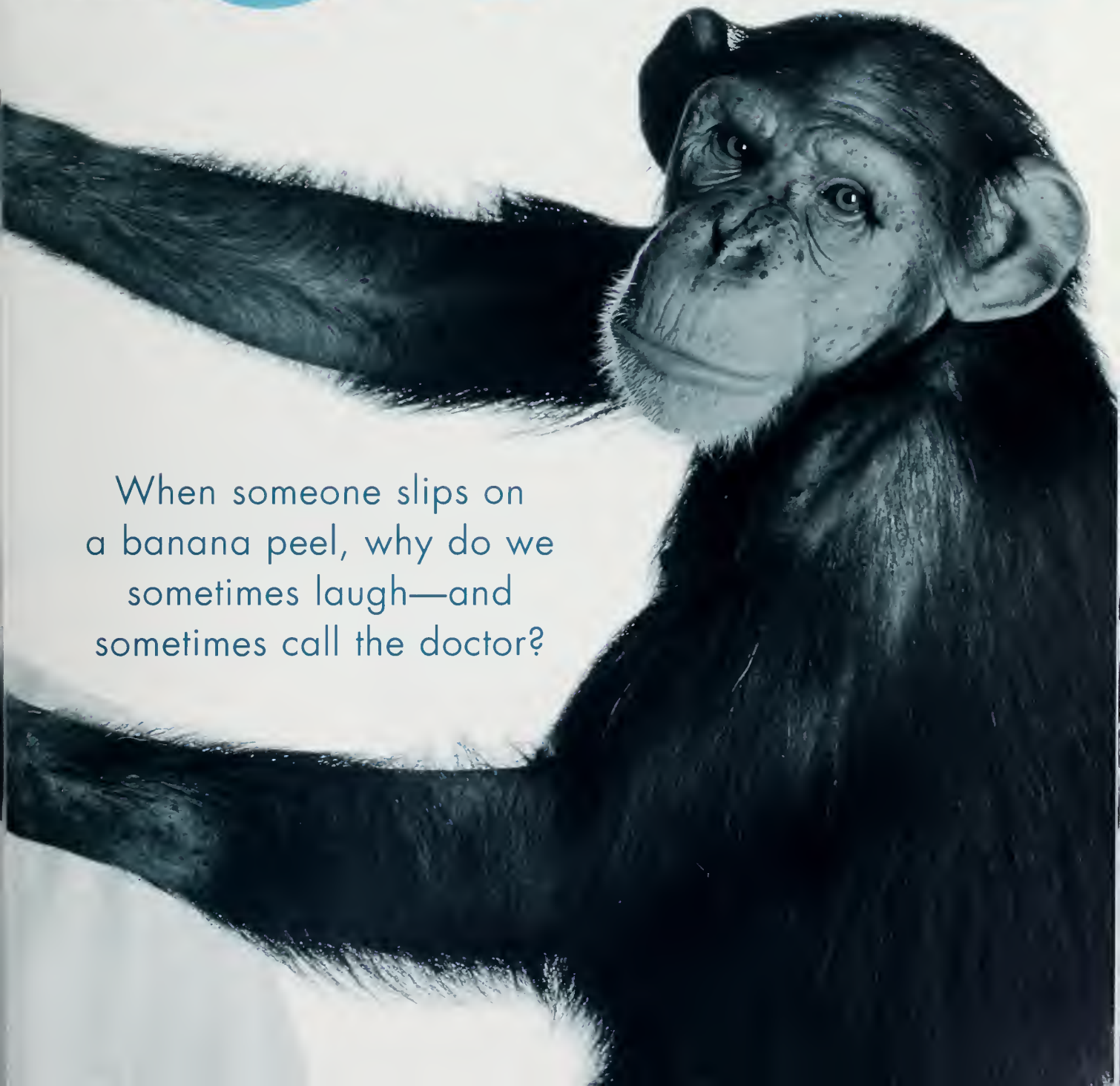
While I spent college low on the evolutionary ladder, vivisectioning slugs, that same college friend, Rob LaZebnik, was slaving over spoofs for the *Harvard Lampoon*. Most evenings found me on Premed Parkway, an infinite row of science library carrels whose monastic underground cement walls magnified every cough and crunch, while Rob more religiously spent his evenings watching Johnny Carson and David Letterman. Taking notes. While Rob and his *Lampoon* friends like Conan O'Brien struggled to wedge themselves inside the door of such shows as *Saturday Night Live*, my premed friends and I went on to medical school as passively as cattle on a conveyer belt.

by ALICE FLAHERTY



BUSINESS

When someone slips on
a banana peel, why do we
sometimes laugh—and
sometimes call the doctor?



COMEDIAN

Mel Brooks

simply one's perspective: "Tragedy is if I cut my finger



From Rob I learned that although laughter may well be the best medicine, prescribing Lipitor is much easier. Even now, when Rob is a well-established writer and producer of sitcoms, the strain he feels from having to be funny ten hours a day makes me grateful for my hospital's cheering atmosphere. This feeling—which comes from being surrounded by people whose problems dwarf mine—borders on *schadenfreude*.

We can perhaps make a case that the wall dividing comedy writers from doctors—masters of tragedy and propriety—is not that thick. Comedians and doctors often emerge from similar back-

grounds—the great physician William Osler and the rubber-faced comic Jim Carrey grew up in neighboring small towns in Ontario, and the Brooklyn immigrant community that produced Nobel-Prize-winning neurologist Eric Kandel also gave us Woody Allen.

An even thinner wall separates Conan O'Brien, renowned for his comic genius, from doctors. He spent the first 18 years of his life in the Brookline home of his father, Thomas O'Brien '54, a Harvard Medical School microbiology professor. Conan's personal story would seem to control for both environmental and genetic influences.

But comic and medical phenotypes remain distinct: Conan once told me how, during high school, his father had shepherd him into a summer job caring for mice in a Brigham and Women's Hospital laboratory. One slow day Conan put his murine charges on a tray, tied helium balloons to the corners, and sent it wafting down the corridor. Fifteen minutes later the tray floated back with a note: "Please return these mice to their cages." That was the end of Conan's medical career.

It's not that doctors are never funny. There is *The House of God*, for example, the blackly comic bildungsroman that

argues that what separates comedy from tragedy is
Comedy is if you walk into an open sewer and die.”

Stephen Bergman '73 wrote under the pseudonym Samuel Shem. Generations of premeds, and even normal people, have laughed out loud reading it—although, after residency, the book seems less like satire and more like simple reportage.

We doctors could perhaps argue that we're not funny because our work is so bound up with tragedy. Comedy is not the opposite of tragedy, though. The two are enmeshed; they are both the opposite of flatness. Comedian Mel Brooks argues that what separates comedy from tragedy is simply one's perspective: "Tragedy is if I cut my finger. Comedy is if you walk into an open sewer and die."

Larry David, co-creator of *Seinfeld*, believes that comedy is related to tragedy because in comedy, as in Olympic diving, you get points for difficulty. Making jokes about death becomes funnier because of its sheer riskiness—it provides your audience with an extra frisson from the likelihood that you will hit your head on the diving board on your way down.

The neurologist V. S. Ramachandran draws his metaphor not from athletes, but from apes. He proposes amused laughter as a primate false-alarm call, a revocation of the need for help. If someone in your tribe slips on a banana peel and breaks his leg, you don't laugh—you call the doctor. But if he slips and gets up immediately, you laugh—at least if you're a monkey, or a human with a taste for slapstick.

My chief exposure to primate humor—or, rather, nonhuman primate humor—came in graduate school. When bored, I would make rounds with the head vet in the animal facility, a huge underground zoo of frogs, mice, and primates. On those rounds the vet acted as simian play therapist, carrying a tin lunchbox of toys that he rotated with godlike impartiality through the cages to keep the monkeys from becoming bored. More successful than his slinkies and rubber balls, though, was the television set he kept tuned to reruns of *Wild Kingdom* and *The Monkees*.

Keeping the primates amused was deemed to be good for their health—pant-hoots, the ape equivalent to laughter, as best medicine. The entertainment also kept the monkeys from masturbating all day, which was thought to be bad for graduate student morale.

Ramachandran's false-alarm hypothesis fits with what little we know about how the brain controls humor perception. Of great importance are parts of the medial forebrain that help detect incongruity. Perceiving humor also activates the same centers for drive and pleasure that kick in during such wayward pastimes as gambling and cocaine use.

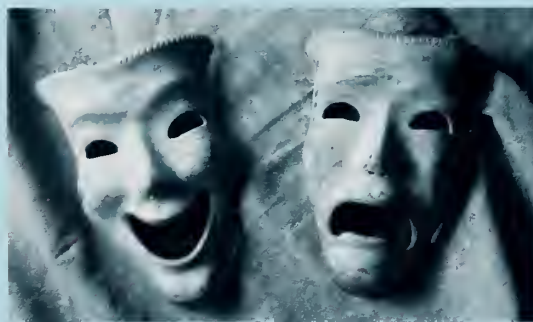
As for the notion that laughter is the best medicine for humans, too, several recent research papers show that watching comedies such as that Marx Brothers classic, *Duck Soup*, can decrease pain perception. Then again, so can watching tragedies like *Hamlet*. Or even watching something merely gory, like *Night of the Living Dead*. Apparently the primary factor is that the stimulus be distracting and arousing enough.

Control of the expression of humor is relatively well localized, much further back in the brainstem than is the perception of humor. Pseudobulbar affect, the uncontrolled release of laughter or tears

French Twist

Molière managed to twist tragedy into a comic medical masterpiece. *The Imaginary Invalid* is usually presented as a play about a healthy man who wants to be sick. For Molière, who wrote it as he was in the throes of tuberculosis, it must equally have been about his own desperate desire to be a hypochondriac rather than a dying man. His doctors had urged him to abandon the theater because the exertion was hastening his death, but his farces were his life. He continued to work—indeed, he wrote the *Invalid* so he could also star in it, able to remain seated throughout the play, on a commode, coughing.

Medicine didn't save Molière; no doctor would come to his deathbed because of his scurrilous play—which portrayed physicians as tricksters profiting from making their patients believe they were ill—and it was just as well, since the preferred treatments of the day were bloodletting and high colonics. But comedy didn't save him, either: on the fourth night



of the hugely successful play, Molière suffered a lung hemorrhage and died, perhaps from the effort of projecting his voice to the laughing audience. Still, his use of comedy as a defense left us the greatest collection of enema jokes in Western literature. ■

PERCEIVING

humor activates the same centers for drive and pleasure that kick in during such wayward pastimes as gambling and cocaine use.

without any experience of the appropriate triggering emotion, can occur when brainstem function is altered. One of my patients, after having a stimulator placed in her brain to control Parkinson's disease, reported a new, involuntary giggle that embarrassed her at the golf club. When I changed the voltage on her stimulator, the giggle disappeared.

Other pseudobulbar patients weep when they should laugh. One construction worker with a brainstem stroke, who sobbed every time I made a mild witticism on rounds, would then sob for real because his tears mortified him.

Perhaps this anatomical link between laughter and tears could be used to argue, however fallaciously, that a little comedy should be added to the daily practice of a profession as tragic as medicine. Humor may be merely an inappropriate psychological defense against suffering, but even black humor is less corrosive than numbness. I learned this from a surgical chief resident who had one of the wickedest senses of medical humor I have ever encountered. On rounds, before we entered a patient's room he would dissect that patient—and the rest of the team—more accurately than any scalpel could.

Yet as soon as he crossed the threshold, his bedside manner was unsurpassingly gentle. He never ignored the suffering of an opiate addict who was hypersensitive to minor pains, or the qualms of anxious patients with dozens of questions. Although his Janusian character troubled me, at least he was alive to his patients. And he brought them alive for the rest

of us too, transforming the large-bowel obstruction in Room 818 into a character from Molière's *The Imaginary Invalid*.

For most doctors, the preferred defense against patients' suffering is to scrub it out of our minds. Nowhere is this avoidance more evident than in patient notes. These desiccated husks of patients' lives are dry not only because we must write them quickly, but also



MARXIST EVOLUTION: Groucho Marx exploited the comic potential of impersonating a doctor not only in *A Day at the Races*, shown here, but also in *Monkey Business*.

because we intentionally strip everything tragic or comic from them. Whether our dryness stems from a desire to be polite, to avoid litigation, or to stand on a pedestal of ponderous scientific rhetoric aimed at rendering our pronouncements more authoritative, by writing dull notes we do our patients a disservice.

If our notes leave out everything that is human—such as the silk scarf an elderly Boston Brahmin has improbably found to coordinate with her johnny—we make our patients less memorable, and that

makes it harder to treat them. Was the 83F w/ COPD, CAD s/p CABG, and CRI the one with ALL=PCN? If the note-writer had impolitely quoted the patient's description of how taking penicillin "made me swole up," you'd remember.

Wise families of ICU patients put up photos of the patients when they were young and healthy to appeal to our sense of tragedy and motivate our efforts to save

what may otherwise look like shells of their former selves. Similarly, the patients who engage us with humor get more of our attention and therapeutic effort.

When we respond to our patients only in measured tones, our advice is less memorable and our patients are less compliant. Humorlessness deadens human communication, which is, after all, propelled by emotion. Rather than spending millions of dollars developing a new blood pressure medicine that is marginally more effective than last year's model, we should communicate warmly and vividly enough to our patients so that they even bother to take the pesky pills in the first place.

Of course, it's not fair to say that all doctors are white-coated pillars of grimness. At Massachusetts General Hospital, where I work, psychiatrists seem to be the best at putting humor to use. George Murray, for example, has earned renown for progress notes that will burn a patient into the reader's memory forever. Unfortunately, the best are too scatological to repeat in an alumni publication.

In the psychiatric interview, humor can open patients up—or intentionally

close them down. Once I watched John Herman, director of clinical services in the hospital's psychiatry department, interviewing a depressed woman who had never seen a psychiatrist before. Although she was ashamed to be there, and guarded, his humor relaxed her. She was soon describing her feelings so openly that she was on the point of tears. He quickly made a joke, and she collected herself. Afterward he asked me why I thought he had cracked the joke.

"Because you're a guy! Guys hate to see people cry," I replied, with all the psychiatric insight that comes from being a neurologist.

"No!" he exclaimed, delighted that I had fallen into his pedagogical trap. "Some patients like to cry; they find it cathartic. But not this one. Self-control was very important to her. If she had cried, she would have been so embarrassed that she would never have returned for her follow-up appointment."

The king of psychiatric humor at our hospital may be Ned Cassem '66, the former department chief. Cassem, a Jesuit priest, does much of his work in end-of-life issues; he even heads the hospital's Optimum Care Committee, usually called the God Squad. Is his ability to be funnier than usual in a role that is gloomier than usual simply one more piece of evidence for the link between comedy and tragedy?

Cassem uses humor to make teaching points memorable to residents, as when he reminds them, with an aphorism, that a family history of suicide escalates a patient's suicide risk: "Suicide is putting your skeleton in other people's closets." He makes his advice memorable to patients in similar ways. Once, for example, he was asked to speak to a family who, for religious reasons, wanted medical treatment withheld from a relative.

"We know that Jesus is watching over her," the son told Cassem.

"I'm sure He is," Cassem replied, "but I've checked, and He's not leaving notes in the chart. So for day-to-day management, I think He's leaving decisions to us."

Non-psychiatrists sometimes dismiss humor, along with the other emotions, as psychiatric turf. Studies have shown, though, that even pathologists and neurologists can be funny on occasion. On rounds when I was a resident, I used to

copy down the clinical pearls the neurology attendings uttered. Soon I had a spin-off column in which I was recording the funny things they muttered. The first column became a handbook of neurology; the second would have to be published under a pseudonym. Nonetheless, funny bits from the second column kept trying to creep into the first. My editors rooted out most of them. One fragment that escaped the censors into the handbook, though, was the jingle Michael Schwarzschild '85 composed for the Movement Disorders Consult Service:

*Trouble with tone?
Just pick up the phone.
Jerky or stiff?
We're there in a jiff.*

Unfortunately, when the jingle hit the Spanish edition it was translated literally, as straightforward clinical advice: "If you are experiencing muscular rigidity, utilize the telephone, please." I have not yet had the nerve to find out what happened to the poem in the Japanese edition; I hope it became haiku.

Later, when giving talks about a second book, I was pleased that the audience generally laughed much harder than the jokes deserved, but I was taken aback to find that their laughter was so tinged with relief. "Thank you so much for being funny," one woman said after one of my talks. "When I saw you were a doctor I was sure this would be boring."

I found that the tighter I rolled my bun and the duller I dressed, the more my humor caught the audience off guard. An advantage that doctors have over comedians, then—besides better job security—is the element of surprise. Because no one expects doctors to be funny, our patients are grateful for even the mildest joke. And, although stress-related illnesses and depression are higher in both comedians and doctors than in the general population, at least we doctors know better how to work the medical system to get ourselves treated.

Then again, we never get invited to host the Oscars. ■

Alice Flaherty '94, PhD, a neurologist at Massachusetts General Hospital, is author of The Massachusetts General Hospital Handbook of Neurology and The Midnight Disease: The Drive to Write, Writer's Block, and the Creative Brain.

Glad Science

People with heart disease are 40 percent less likely than healthy people to laugh often and to use humor to extricate themselves from uncomfortable situations.

[*International Journal of Cardiology*, 2001;80:87-88]

Primary care physicians with no medical liability claims filed against them tend to laugh and to use humor more often with patients than those with claims against them.

[*JAMA*, 1997;277:553-559]

One study found that skin welts shrank in allergy patients who watched Charlie Chaplin's classic comedy *Modern Times*, but not in patients who watched a video about the weather.

[*JAMA*, 2001;285:738]

The nucleus accumbens—the some region of the brain that has been shown to be activated by rewording drugs such as cocaine and amphetamines—is activated when a person sees or hears something funny.

[*Neuron*, 2003;40:1041-1048]

Researchers have found a relationship between a decline in cognitive abilities in the elderly and a higher error rate in picking out humorous punchlines and cartoons.

[*Journal of the International Neuropsychological Society*, 2003;9:855-863]



PHOTO COURTESY OF BRIAN AND WENDY HODGA

Medical training
can warp your sense
of humor—and
humor can help
you make sense of
your medical training

SICK



WHO WERE THESE MASKED MEN?: In an early housestaff show at the Peter Bent Brigham Hospital, leading HMS faculty members were spoofed (from left): Elliott Cutler, Chonning Frothingham, Henry Christian, Horvey Cushing, John Homans, S. Burt Wolbach, and Merrill Sosman.

by **PERRI KLASS**

DID YOU HEAR THE ONE ABOUT THE TEENAGE GIRL WHO went to the health center for an itchy insect bite and ended up taking a pregnancy test? Or the one about the constipation epidemic during an on call weekend? Or that knee-slapper about the grandfather who started having chest pains on the baby ward, where the only oxygen masks available were sized for infants?

These are the kinds of unfunny things I find funny. I've been writing about medicine ever since I entered medical school, and I'm afraid I've often succumbed to the easy temptation of presenting myself in print as rather noxiously sensitive.

But every so often I catch myself in some unduly smug and self-congratulatory locution, and I pause, as an imaginary conga line of pediatric residents comes snaking across my brain. And what's that lyric they're singing? Could it be, perhaps, my own catchy ditty: "He was too young to come out of his mother/He should have stayed on inside and been fine/He was too young to come out of his mother/He got a tube and a vent and a line/It was an itsy bitsy teenie weenie hypercarbic seizing preemie." You get the idea.

As a resident, I probably laughed harder over our hospital housestaff shows—writing, rehearsing,



HUMOR



THESE DAYS

I don't
at the expense of other doctors—I'm too

performing, and watching them—than I have ever laughed over anything. I still giggle when I think of some of our finer moments—although, out of a strict HIPAA-inspired sense of confidentiality, I shall not reveal so much as a single lyric, line of dialogue, or even sight gag that was not my own, thereby sparing my residency colleagues—all no doubt highly distinguished leaders in their fields today—much embarrassment.

I know, of course, why I laughed so hard. It was because I desperately needed to laugh, because I was so deeply engaged in learning how to be a pediatrician, and because I was so anxious and scared and charged up and sleep-deprived. It was because I was living close to the edge of other people's tragedies and laughing in the face of a new and profound understanding of the vulnerability of human life.

Humor thrives on tension and anxiety—and sometimes, let's be honest, on hostility. One of my fellow residents told me that two particular lines from one of my songs in our holiday show—sung to the tune of "Comedy Tonight"—gave him his happiest residency moment. Like all of us, he had spent many complicated nights in the newborn intensive care unit and many agonizing mornings second-guessing the ethical implications of the decisions he had made. It felt so good, he said, to stand on stage, face the whole gang of our teachers, and belt out, after a chorus of "Old malformations, new complications," these lines: "We save their lives, we are so clever! And then their parents get them forever!" And yes, it was just a little bit hostile—toward our mentors, toward the mingled expertise and help-

lessness of our profession, and perhaps even toward the tragic complexities of life and death.

Maybe I've always had a warped sense of humor. Maybe we all do—a particular is-nothing-sacred kick often distinguishes successful humor, and there is always relief in laughing at the things that scare you, rile you, worry you, or haunt you. But as I became a doctor—as medical material became the very stuff of my life—I stopped noticing that there was anything twisted about medical humor.

Every workplace features its unique brand of humor, I suppose, just as every workplace has its own rules, traditions, and jargon. Air traffic controllers (talk about tension and anxiety) probably make bad pilot jokes, and we're just as glad not to hear them. For all I know, there are strong traditions of florist humor, gas station attendant humor, even mortician humor. But medical humor has an especially grand—or especially tawdry—pedigree.

After all, we are a profession with a tradition of hierarchy and even pomposity, which always fuels rich opportunities for humor at the expense of those in the upper echelons—just ask anyone who has ever served in the military.

We also deal with bodily functions, and as the mother of a fourth-grade boy, I can attest to the profound and—if you will pardon the expression—gut-level appeal of any humor based on the noises, aromas, and substances produced by the human body. We all know that, despite their limited understanding of pathophysiology and biochemistry, my son and his ten-year-old friends could appreciate many of the jokes in your

standard medical school show; orifices are just enduringly funny.

Our training involves a deliberate attempt to help us discuss all these bodily functions without any sense of embarrassment—in other words, all the good work I am doing with my fourth-grade son about what is *not* funny, especially at the dinner table, will go right out the window should he ever find himself in a medical training program.

Doctors have to cope with life and death—or with the idea of life and death—and with the frailties of the flesh. This engenders a certain kind of tension, brought about, no doubt, by our enforced confrontation with certain bleak realities that others might prefer to escape by denial. And this tension, in turn, cries out to be broken, and to be broken with humor, the blacker the better.

I grew up watching famous doctor faces on television—not only Marcus Welby's furrowed brow, but also Hawkeye Pierce's sloppy grin on *M*A*S*H*. So it was with zeal that, a few years ago, I tried writing a sitcom about medical school. I was working with my brother, a screenwriter by profession, and together we assembled a fictitious group of medical students and then enjoyed ourselves at their expense.

I tried to write about the academic tension gripping our characters as they began their first year—and then to show them kicking back, acting silly at a party, and ending up in dubious romantic entanglements. I exploited their propensity toward self-diagnosis in the virginal supernerd who became convinced that he had mysteriously acquired a sexually transmitted disease and kept coming up with unlikely

have time to engage in coarse, insensitive, tasteless jokes busy telling stories on my patients and their families.

diagnoses ("Oh, no, I have mucocutaneous leishmaniasis!").

But whatever hijinks we came up with weren't edgy enough for the TV people; they kept asking us to "ratchet it up." Thus, my poor medical students ended up playing pin-the-penis-on-the-cadaver at their party—did I miss this in medical school? was I just not invited to the right parties?—and my poor virginal supernerd had a run-in with a singularly well-equipped yet vindictive young woman who superglued kitty litter to his groin ("Oh, no, I have leprosy!"). And, even after all that, the network mysteriously turned its back on our biting medical satire.

But now I'm a grownup doctor, right? Those silly madcap medical school and residency days are far behind me. I may suppress a giggle at the memory of certain tasteless lyrics I once had something to do with authoring, but those were my pressured, sleep-deprived training days. Now, I am pleased to report, I have become a matriarch, an authority figure—oh, hell, let's admit it, I have become that common residency figure of fun—the LMD, the pain-in-the-neck local doc.

Now it's me on the other end of the phone late at night trying to convince the Emergency Department resident that, despite the results of his review of the literature, I sent the kid in for a head CT and that's what I want, damn it. And yes, I can just imagine the faces that resident is making as he listens to my diatribe—and yes, I can imagine his choice of words—and I'm sure they are choice—when he finally gets to hang up on me and report back to his colleagues. But these days I don't have time in my busy schedule to engage in coarse, insensitive, tasteless jokes at the expense of

other doctors—I'm too busy telling stories on my patients and their families.

Oh, I have my standing jokes at the community health center where I work, such as the taxi-voucher family and the lady obsessed with getting her child door-to-door transportation from the public school system, even though the child seems perfectly healthy. And yes, of course, I know there are serious issues here—as I talk to the social worker of the family who can't keep their children's primary care appointments without constant taxi vouchers to transport them hither and yon, or as I consider the possibilities of Munchhausen's by proxy in a mother who seems determined to pin some drastic diagnosis on a healthy child.

But it also makes for a funny story, a wait'll-you-hear-this one moment, when I hang up the phone and turn to my colleagues, who have been listening with interest to my side of the conversation ("Well, the public schools have gotten pretty strict these days—I don't think they'll agree that he needs door-to-door transportation just because his fingers get cold—have you thought about buying him warmer gloves?").

And I can't help it, there's also a laugh to be had when that teenager comes in for something to make her mosquito bite stop itching and then casually mentions, as she's leaving with her prescription for hydrocortisone cream, that she hasn't had her period in six weeks, and no, she hasn't been really careful about using condoms every time, and also, she's been having this discharge. If you have ever practiced adolescent primary care, you should be laughing by now.

So you laugh in recognition, and sometimes in appreciation—for all my medical authority and privileged social status, I

am easily intimidated, and some part of me can't help cheering for even the most difficult patients who have the sheer gall to stand up to doctors, the hospital, or the medical system, even if it's just to try to weasel more taxi vouchers. And you laugh at yourself, of course—if you don't have some good stories about diagnoses you failed to make or patient relationships you mishandled, if you aren't the butt of a good many of your own funny stories, then you're in danger of entering the twilight world of the terminally self-righteous.

So medical humor is still my way of acknowledging the unpredictability of reality, even when the weight of all evidence-based medical knowledge is brought to bear. As it said on a sign I used to see hanging on office doors back when I was a graduate student in biology, "Under the most rigorously controlled conditions of pressure, temperature, humidity, and other variables, the organism will do as it damn well pleases."

Pathogens don't always do what they're supposed to do. Patients and their families don't always do what they're supposed to do. Hospitals don't always do what they're supposed to do. Insurers never do what they're supposed to do. And most of all, of course, doctors don't always do what we're supposed to do. Could it be that humor, even terrible humor, is something of a saving grace? ■

Perri Klass '86 is an associate professor of pediatrics at Boston University School of Medicine, a pediatrician at Dorchester House Health Center, and the medical director of Reach Out and Read. Among her recent books are The Mystery of Breathing, a novel, and, with Eileen Costello, MD, Quirky Kids: Understanding and Helping Your Child Who Doesn't Fit In.



A young Jazz Age intern worries that some improvised words at a deathbed may well prove to be his last

IT

WAS THE FIRST DAY OF MY INTERNSHIP AT THE Boston City Hospital and after some cursory instructions from my department chief, I was on my own. The telephone rang, and the nurse who answered it said I had better get over to Ward K and pronounce a man dead right away or there would be hell to pay. They had been looking for me all afternoon and where the devil was I? I knew nothing about pronouncing anyone dead, so I started out with much misgiving.

En route, I ducked into the hospital library, where a young lady said she had nothing listed on this matter, but the information I needed was probably on file in the superintendent's office under "Lex Mortem Dictu." I headed straight to that office, where I found only an old man who acted as messenger boy for the first assistant; he had worked there for many years but couldn't remember just exactly how to pronounce a man dead. Perhaps, he suggested, I should ask another intern or a nurse; someone, he was sure, would be happy to enlighten me.

Unfortunately I met no one on my way to Ward K. When I finally arrived I found a huddle of frowning nurses with their arms folded tightly across their chests. They had been waiting almost an hour for me, they said, and they could not move the body until a doctor had officially pronounced the man dead. Furthermore they needed the bed for another patient. They were clearly in no mood to answer my questions about the proper procedure, so I reluctantly made my way through the unfriendly cluster to the middle of the ward, where a bed was screened. I entered the enclosure to find it crowded with nurses and orderlies.

PHOTO: SPIKE MAFFORD/PHOTODISC GREEN

by ALBERT HYMAN

DE

RECKONING

AD

WHEN

I reached the head of the bed
He was unquestionably dead

When I reached the head of the bed I slowly pulled down the sheet, exposing an emaciated man. He was unquestionably dead because the nurses had been waiting for nearly an hour, but was that sufficient evidence? Had the usual tests of death been made? What were these tests and who had made them? I somehow had to conceal my inexperience.

I fumbled for the man's pulse; his skin was ice cold but I thought I could just detect a faint yet rapid pulse until I realized that I was gripping his wrist so tightly that the pulsation was mine. I took out my stethoscope and listened intently to his chest, but I could hear no sounds. I then opened his eyelids and noted that the pupils were unequally dilated. By this time I could sense considerable rustling among the nurses and orderlies. I overheard tense whispers about hurrying it up and getting the job done already.

I continued to examine the man, though, desperately hoping that someone would finally give me a clue about the next step. But I could gather nothing constructive from the undertones. So I finally straightened up, looked significantly at the head nurse, and declared that she was correct: the man had undoubtedly expired.

She snorted and exclaimed loudly, so everyone in the ward could hear, "Just go ahead and pronounce the man dead and stop all this nonsense!"

I began to feel weak. The thought occurred to me that the repeated use of the word "pronounce" must bear some special significance; it must mean that something must be said in a particular way, with some particular legal phraseology. I dimly recalled seeing a play in which a character had died and the attending doctor had made a public statement. I tried desperately to recall what he had said, and then suddenly remembered a few words that seemed to cover the situation.

With all the dignity I could summon, I intoned the following statement: "By

virtue of the authority vested in me by the Commonwealth of Massachusetts and in accordance with the rules and regulations of the Health Department of the City of Boston, I, Dr. Hyman, a duly authorized intern of the Boston City Hospital, do hereby and hereon officially pronounce this man dead, and in witness thereof I hereby and in the presence of these witnesses set my hand and signature."

When I finished, a stunned silence seemed to settle over the onlookers. The head nurse in particular looked shocked, and I was no little alarmed at her pallor when I asked for the certificate to be signed. After a moment's hesitation, she retrieved a slip of paper from her desk. I quickly initialed it and then strode out of the ward. At the door I turned and saw everyone still frozen in an oppressive hush.

On my way back to the main wards I again felt weak as I wondered how much of the ceremony I had fouled up; I had obviously done something quite contrary to the usual procedure. A grumbling yet jocular throng had turned deeply solemn upon my pronouncement. The more I reviewed the situation the more worried I became. I resolved to ask the first house officer I met how I could extricate myself from this mess.

It was getting late and although I had no appetite I went to the dining room hoping to run into my senior attending. But only a few interns were there and the waitress had begun to scold me for coming in so late when the telephone rang. "If you're the new intern and your name is Dr. Hyman, you'd better get up to the superintendent's office right away," she said. "But have a cup of coffee first, because you're going to need it."

I gulped down the hot brew and bounded upstairs. If the front office was calling me, I was definitely in trouble because I had heard that only a few complaints ever reached the stage where the superintendent was called in. If this was

happening on my first day at the hospital, my future was dim indeed.

It was with a heavy heart that I entered the office. The superintendent was pacing up and down and seemed to be arguing with several of his assistants. When I opened the glass door, they all looked rather savagely at me. I felt queasy. The first assistant wasted no time in yelling, "What the hell have you been doing in Ward K this afternoon? You've turned the whole hospital upside down. Couldn't you pronounce a man dead without raising all this rumpus?"

Then the superintendent, a kindly man, interrupted and said, "Now young man, will you please tell us exactly what went on in Ward K?"

So I explained the situation, prefacing my remarks by saying that I was not familiar with the "Lex Mortem Dictu" in use at the hospital, so I had substituted Section 110 of the 1905 Code. Everyone stared at me, and then the superintendent said, "Please tell me the exact statement that you made." I repeated my earlier pronouncement word for word, with as much dignity as I could muster.

Again a stunned silence fell. Finally the superintendent turned to the first assistant and said, "Charlie, first thing in the morning run down to City Hall and get a copy of that Section 110 of the 1905 Code. It's about time we did this thing right; I've been here damn near 26 years and it's the first time I've ever heard the proper way of pronouncing a man dead." Then he said to me, "All right, young man, you did the right thing. Just forget about the rough way we were handling you. Goodbye and thank you very much."

I returned to the wards in an even gloomier mood than before I had been summoned; I cursed myself for citing the 1905 Code. Why hadn't I had the courage to confess my ignorance? I was in a worse mess now. When they looked up that code there would be nothing in Section 110—if there even was such a section—

I slowly pulled down the sheet, exposing an emaciated man. because the nurses had been waiting for nearly an hour.



PHOTO: DOROTHY PRESS/STINE

that had anything to do with pronouncing someone dead. I found the house officers' quarters and stumbled into bed.

The next morning, I was relieved when my department chief smiled as I told him about my predicament. He had heard all about it from the front office. "Chief," I said, "I didn't want to confess this to anybody, but I honestly don't know how to pronounce someone dead. There was nothing in the notes you gave me yesterday. Tell me, how does one do that?"

The chief looked at me for a long time. Finally he said, "My boy, you have asked a question that every physician who has ever been present at the death of a patient has pondered. I know of no hospital with a specific ritual for pronouncing a man dead. By word of mouth, one intern conveys the

traditional method of the institution to another and eventually the pronouncement of death may become just a nod of the head. Yesterday you inadvertently stirred up a problem with no special solution. It was lucky that you remembered that Section 110 of the 1905 Code. But for now the front office has a hot potato in its hands, and I advise you to keep away from that part of the hospital." He then led the way into the operating room, and we said nothing further about the matter.

Pending a continued search for Section 110 of the 1905 Code, the superintendent issued a memorandum about the procedure to be followed in pronouncing a patient dead. It stated that henceforth house officers should conduct themselves with decorum and

confine their remarks to a simple statement, the text of which had been carefully typed into the body of the memorandum. Reading it, I was astonished to find my speech replicated verbatim, my own feeble recreation of words a stage actor had uttered so many years before. ■

Albert Hyman '18 was a cardiologist whose interest in cardiac resuscitation led him to witness numerous patient deaths early in his career. In the 1930s, together with his engineer brother, he invented and patented the "artificial pacemaker." Operated by a hand crank and a spring motor that turned a magnet to apply electricity, the device was a breakthrough, though it was not widely accepted by the medical community at the time. This essay was excerpted from an article that appeared in the January 1955 issue of the Bulletin.



Keeping a straight face isn't
always all it's cracked up to be

THE URGE TO TITTER

[in the clinical encounter]

AMONG THE GREAT HAZARDS OF LIFE, NOT TO MENTION MEDICAL PRACTICE, IS THE sudden impulse to snicker at precisely the wrong time or in the wrong setting. And the nasty truth is that nothing is more irresistibly funny than when your laughter bubbles up exactly under these conditions.

Church services are classically wrong time, wrong place. My sharpest early memory of uncontrollable and discreditable giggling comes from the time my Auntie Mame—her real name—hailed me, at the age of ten, to a small church north of Seattle. During the service Mamie suddenly nudged me, grinning, and pointed to a plaque on the wall. It paid tribute to the “pioneer women of Woodland,” which long before had been a settlement in the area. Mamie’s joke was at best a weak one. The community had since dwindled to a dilapidated roadside tavern, so the plaque now seemed to commemorate these spirited women’s founding of a disreputable bar. »

by WILLIAM IRA BENNETT



TO BE HUMAN

is, from time to time, to appear ridiculous.

Had I not been surrounded by strangers engaged in holy behavior I would have barely glanced up from my sneaked-in book, shot Mamie a condescending smile, and returned to my surreptitious reading. But we were in a church—and the church was packed. I immediately began a series of small respiratory explosions that swiveled all praying heads toward my deliriously amused self. Only Mamie's complicity protected me from the thin-lipped consequences of Lutheran disapproval.

One's psyche survives this sort of thing with relative ease and a clean conscience. No element of the personal had played a part—I was mocking nobody's physical appearance or habits of speech, nobody's taste in clothing or love. Unfortunately, a titter without a whiff of mockery is more the exception than the rule. Often when the urge wells up, it is precisely because someone else has tumbled into ridiculousness.

To be human is, from time to time, to appear ridiculous. This sad axiom has an unhappy corollary: from time to time, someone else will notice. With any luck the person witnessing our descent into the ludicrous kindly empathizes with the gaffe, or has already achieved sainthood and is above it all, or has practiced yoga breathing for decades and can suppress laughter indefinitely. But none of these conditions is common, so the likelihood is high that one will eventually become the instigator or the recipient of an urge to titter.

Another home truth is that intimacy and silliness go together like love and marriage. Indeed, the backbone of a solid relationship has to be the sheer willingness to tolerate a partner's descent into ridiculousness. Absent such tolerance, a divorce court is the likely next stop.

The patient-doctor relationship is a perfect setup for ill-timed laughter. The clinical encounter is intimate, so one party or the other is always at risk of getting caught in a moment of absurdity.

(I exempt from this discussion the merely humiliating, which is never an occasion for laughter. A great deal of medical practice is humiliating for patients, and all involved must soldier on as though they hadn't noticed. I remain astonished, for example, at the sangfroid of my gastroenterologist.)

While the patient may be relatively uninhibited in expressing mirth, the physician had damned well better conceal all signs of amusement until the patient is safely out of earshot. Divorce courts are bad enough; malpractice litigation has to be worse. But this is also exactly the problem. What is forbidden, as Adam learned to our universal cost, is the most tempting.

I first began to think about the vicissitudes of tittering over a decade ago, when I was locked in unintentional combat with a patient who had concluded, on a week's acquaintance, that I was ruining her life in every possible way. We had been discussing whether I would issue her a pass to leave her psychiatric unit for a few hours, but our conversation rapidly devolved into her sermon on my resemblance to Cain, Esau, and Judas Iscariot.

It was, in its way, a bullfight, with me as lumbering bull. Every time I thought it was over, there was another shake of the cape, another verdict, and always the glint of steel as she waited for me to make my misstep. The pressure was building, because the only resolution to our face-off I could imagine was that I would burst into helpless laughter, whereupon she would neatly clip off my ears and tail, and I would need, at the very least, another profession, if not reconstructive surgery. And all the while, I was baffled by my impulse to laugh, because on the surface our conversation was more exasperating than funny.

Having matured a bit since Mamie had taken me to church, I held on during the harangue, although it was becoming ever less clear how I could both breathe and continue the conversation. Then, at

the last possible moment, the patient stopped and drew herself back. She looked at me and then at her knees and said, "Now you're going to laugh at me, just the way my father always did." Nothing made me love her more than that magic moment when she dropped the cape, tossed the sword aside, and showed me the way back to the bullpen. Or, more accurately, she showed me her psychological script and pointed out the role in her internal drama that I had, both unwittingly and guiltily, taken up.

So I got off easy. But this experience started me on a search in both the medical literature and real, honest-to-goodness literature for some guidance on the topic of physicians tittering out of turn. It was, as you might imagine, a nearly dry well. Almost everything else that a doctor can do badly or wrong is amply covered—largely in *Madame Bovary*, if you ignore the adultery and stay with the good parts. But I know of only one solid source on the problem. It is a luminous episode in Woody Allen's otherwise puerile 1972 film *Everything You Always Wanted to Know About Sex (But Were Afraid to Ask)*.

My movie guide gives EYAWTKAS (BWATA) three stars, which can only be explained by the segment starring Gene Wilder as Doug Ross, a mild-mannered physician. The doctor is in his office when a shepherd walks in, insisting on an appointment. The shepherd gradually makes clear to the doctor that he has succumbed to one of the hazards of his profession, falling madly in love with a sheep. We watch as Dr. Ross absorbs what he has been told and then, for 23 seconds (I've counted), keeps himself from bursting into laughter. The camera remains on Wilder's face as the actor puts in a half minute that transcends his entire performance in *Willy Wonka and the Chocolate Factory*.

Dr. Ross successfully keeps himself from tittering, but he *wants* to titter, and the rest of Allen's tiny masterpiece—approaching *Madame Bovary* in subject matter and intensity—hinges on this ter-

rible fact. Confident of his ability to resist her charms, Ross meets the ewe. He soon succumbs and then risks—and loses—everything for her. In Allen's later doctor movie, *Crimes and Misdemeanors*, an ophthalmologist has his mistress rubbed out, but he gets off relatively easily compared with Dr. Ross, whose far graver crime was, after all, that he condescended to the shepherd's desire and *felt* like snickering.

We must not imagine, however, that condescension is only the doctor's risk, whereas ridiculousness is only the patient's. Like Falstaff, I have been dumped more than once into the laundry hamper of a patient's amusement and have learned that horror and humor surreptitiously hold hands.

Not long after I stopped myself from chuckling at one patient's accusations of sabotaging her life, I was treating another, much older woman, who was confined to a dilapidated psychiatric ward against her will. Her state of mind was such that she would exchange few words with her captors, me the chief among them. She would sit erect in the day room of the ward and provide only her name (a false one), rank (fanciful), and serial number (which did not correspond with the medical record, but who was I to quibble?).

This patient knew me as the archfiend, but every day I would saunter by and ask how she was doing as though I were utterly ignorant of my status in her cosmology. One morning I found her in her usual spot sitting near half a dozen other patients, all of them quietly preoccupied with their own thoughts. I went through my routine, asking her how she was.

"You're asking me how I am," she said. "Why are you asking me how I am?"

Delighted at the opening, I rushed in. "Well, I'm your doctor," I said brightly, "so it's good for me to know how you are." I thought the patients nearby smiled slightly, approving of my good humor and good faith.

She waited a beat. "You say you are a doctor," she answered, sitting ever so



EMBRACEABLE EWE: In *Everything You Always Wanted to Know About Sex (But Were Afraid to Ask)*, Gene Wilder's character, a primary care provider, comes to rue his mirth at the expense of a sheep-besotted patient. In the final shot, the ruined doctor is seen sprawled on the sidewalk, swilling a bottle of Woolite.

slightly more upright. "I do not think you are a doctor. I think you are a shoe salesman, and I do *not* need any shoes today, thank you."

Although my patient was in the midst of an episode of mental illness, from which she soon recovered to display an infinitely sweet nature, that morning she nailed me neatly in front of a small but appreciative audience, none of whom laughed out loud. Too callow and embarrassed to do the right thing, I muttered something and strode off, as though I had a purpose. Only later did I realize what would have been the proper response: sit right down and have a good guffaw with her and our audience.

But perhaps the most ridiculous I've ever felt as a physician was some 35 years ago, at the beginning of my career, when I was supposed to be caring for an elderly woman who had entered the last days of her life. Mrs. Edel, as I'll call her, lay in a hospital bed, in considerable pain and barely able to move, but utterly without complaint and with a continuing lively interest in the events around her. Her heart had reached the end of its useful life. Her circulation had slowed to the point that in places the blood was simply turning solid; her legs

were so deprived of blood that they had become practically inert.

For some insane reason, I believed it was my obligation to come to her bedside each day and ask her to wiggle her toes. Whenever I did this, she lay there unmoving—because she couldn't move. Yet my neurology professors had often stressed the importance of motivating patients to do such things as touching their noses accurately, arm wrestling with me, or reciting the names of U.S. presidents. The motivational technique they imparted, at least to me, was to shout.

So I repeated my instruction several times, louder and louder: "Wiggle your toes, Mrs. Edel!" My telling her to do this was pointless, and if anything could be beyond pointless, it was my habit of shouting the command. On the next-to-last day of her life, as my voice rose once again, Mrs. Edel gazed up at me from her bed, and a positively impish smile came to her face. She looked me straight in the eye and said, with something just short of a titter, "By me, dat's viggling." ■

William Ira Bennett '68, who practices psychiatry in Cambridge, Massachusetts, is editor-in-chief of the Harvard Medical Alumni Bulletin.

PHOTO BY ARTIST JEFFREY



THE ETIOLOGY AND TREATMENT OF CHILDHOOD

For decades now,
physicians have
turned a clinical
eye on small fry.
Why, then, does the
epidemic persist?

by JORDAN W. SMOLLER

CHILDHOOD IS A SYNDROME THAT HAS ONLY RECENTLY begun to receive serious attention from clinicians. The syndrome itself, however, is not at all recent. As early as the eighth century, the Persian historian Kidnôm made references to "short, noisy creatures" that may well have been what we now call "children." The treatment of childhood, however, was unknown until the twentieth century, when so-called child psychologists and child psychiatrists became common.

Despite this history of clinical neglect, it has been estimated that well over half of all Americans alive today have experienced childhood directly (Seuss, 1990). In fact, the actual numbers

are probably much higher, since these data are based on self-reports that may be subject to social desirability biases and retrospective distortion.

The growing acceptance of childhood as a distinct syndrome is reflected in its proposed inclusion in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, or DSM-V, slated for publication in 2010 by the American Psychiatric Association. Researchers are still in disagreement about the significant clinical features of childhood, but the DSM-V will almost certainly include the following core markers: congenital onset, dwarfism, emotional lability and immaturity, knowledge deficits, and legume anorexia. >>





CHILDREN

are an “out-group.” Because of their intellectual handicap, they are even denied the right to vote.

Clinical Features of Childhood

Although this paper focuses on the efficacy of conventional treatment of childhood, the five clinical markers mentioned above merit further discussion for those unfamiliar with this patient population.

Congenital onset. In one of the few existing literature reviews on childhood, Temple-Black (1982) has noted that childhood is almost always present at birth, although it may go undetected for years or even remain subclinical indefinitely. As one psychologist has put it, “we may soon be in a position to distinguish organic childhood from functional childhood” (Rogers, 1979).

Dwarfism. This is certainly the most familiar marker of childhood. It is widely known that children are physically short relative to the population at large. Indeed, common clinical wisdom suggests that the treatment of the so-called small child (or “tot”) is particularly difficult. These children are known to exhibit infantile behavior and display a startling lack of insight (Tom and Jerry, 1967).

Emotional lability and immaturity. This aspect of childhood is often the only basis for a clinician’s diagnosis. As a result, many otherwise normal adults are misdiagnosed as children and must suffer the stigma of being labeled as children by professionals and friends alike.

Knowledge deficits. While many children have IQs at or even above the norm, almost all will manifest knowledge deficits. Anyone who has known a real child has experienced the frustration of trying to discuss any topic that requires some general knowledge. Children seem to have little understanding about the world they live in. Politics, art, and science—children are largely ignorant of

these. Perhaps it is because of this ignorance, but the sad fact is that most children have few friends who are not, themselves, children.

Legume anorexia. This last identifying feature is perhaps the most unexpected. Folk wisdom is supported by empirical observation—children will rarely eat their vegetables (Popeye, 1957).

Causes of Childhood

Now that we know what it is, what can we say about the causes of childhood? Recent years have seen a flurry of theory and speculation from several perspectives:

Sociological model. Émile Durkheim was perhaps the first to speculate about the sociological causes of childhood. He points out two key observations about children: the vast majority are unemployed, and they represent one of the least educated segments of our society. In fact, it has been estimated that less than 20 percent of children have had more than a fourth-grade education.

Clearly, children are an “out-group.” Because of their intellectual handicap, they are even denied the right to vote. From the sociologist’s perspective, treatment should be aimed at helping assimilate children into mainstream society. Unfortunately, some victims are so incapacitated by their childhood that they are simply not competent to work. One promising rehabilitation program (Spanky and Alfalfa, 1997) has trained victims of severe childhood to sell lemonade.

Biological model. Again, the observation that childhood is usually present from birth has led some to speculate on a biological contribution. An early investigation by Flintstone and Jetson (1960) indicated that childhood runs in families.

Their survey of more than 8,000 American families revealed that over half contained more than one child. Further investigation revealed that even most non-child family members had experienced childhood at some point.

Impressive evidence of a genetic component of childhood comes from a large-scale twin study by Brady and Partridge (1972). These authors studied more than 106 pairs of twins, looking at concordance rates for childhood. Among identical or monozygotic twins, concordance was unusually high (0.92): when one twin was diagnosed with childhood, the other twin was almost always a child as well.

Psychological models. Among the more familiar psychologically based theories of childhood is Seligman’s “learned child-ishness” model, which holds that individuals who are treated like children eventually give up and become children. As a counterpoint to such theories, some experts have claimed that childhood does not really exist. Szasz has called childhood an expedient label. In seeking conformity, we handicap those whom we find unruly or too short to deal with by labeling them children.

Treatment of Childhood

Efforts to treat childhood are as old as the syndrome itself. Only in modern times, however, have humane and systematic treatment protocols been applied. In part, this increased attention to the problem may be attributed to the sheer number of individuals suffering from childhood. Government statistics reveal that more children are alive today than at any time in our history. To paraphrase P. T. Barnum: “There’s a child born every minute.”

The overwhelming number of children has made government intervention inevitable. The nineteenth century saw the institution of what remains the largest single program for the treatment of childhood—public schools. Under this colossal program, individuals are placed into treatment groups based on the severity of their condition. For example, those most severely afflicted may be placed in a “kindergarten” program. Patients at this level are typically short, unruly, emotionally immature, and intellectually deficient. Therapy essentially becomes one of patient management and of helping the child master basic skills, such as finger-painting. Unfortunately, the school system has been largely ineffective. Not only is the program a massive tax burden, but it has failed even to slow down the rising incidence of childhood.

Faced with this failure and the growing epidemic of childhood, mental health professionals devoted increasing attention to the treatment of childhood. Given a theoretical framework by Freud’s landmark treatises on childhood, child psychiatrists and psychologists claimed great successes in their clinical interventions.

By the 1950s, however, the clinicians’ optimism had waned. Even after years of costly analysis, many victims remained children. The following case (taken from Gumbie and Pokey, 1957) is typical. Billy J., age eight, was brought in for treatment by his parents. Billy’s affliction was painfully obvious. He stood only four foot three and weighed a scant 70 pounds, despite his voracious eating habits. Billy presented a variety of troubling symptoms. His voice was noticeably high-pitched for a male. He displayed legume anorexia, and, according to his parents, often refused to bathe.

Billy’s intellectual functioning was also below normal—he had little general knowledge and could barely write a structured sentence. Social skills were also deficient. He often spoke inappropriately and exhibited “whining behavior.” His parents reported that his condition had been present from birth. The diagnosis was “primary childhood.” After years of painstaking treatment, Billy improved gradually. By age eleven, his height and weight had increased, his social skills had broadened, and he had become functional enough to hold down a paper route.

After years of this kind of frustration, startling evidence has come to light suggesting that the prognosis in cases of childhood may not be all gloom. A critical review by Fudd (1991) noted that studies of the childhood syndrome tend to lack careful follow-up. Acting on this observation, Moe, Larrie, and Kirly (1993) began a large-scale longitudinal study. These investigators studied two groups: one with 34 children currently engaged in a long-term conventional treatment program, the other with 42 children receiving no treatment. All subjects had been diagnosed as children at least 4 years previously, with a mean duration of childhood of 6.4 years.

At the end of one year, the results confirmed the clinical wisdom that childhood is a refractory disorder—virtually all symptoms persisted and the treatment group was only slightly better off than the controls. The results, however, of a careful ten-year follow-up were startling. The investigators (Moe, Larrie, Kirly, and Shemp, 2003) assessed the original cohort on a variety of measures. General knowledge and emotional maturity were assessed with standard mea-

sures. Height was assessed by the metric system (see Ruler, 1923), and legume appetite by the Vegetable Appetite Test (VAT) designed by Popeye (1968). Moe et al. found that subjects improved uniformly on all measures; indeed, in most cases, the subjects appeared to be symptom-free. The researchers also reported a spontaneous remission rate of 95 percent, a finding that is certain to revolutionize the clinical approach to childhood.

These results suggest that the prognosis for victims of childhood may not be as bad as we have feared. We must not, however, become complacent. Despite its apparently high spontaneous remission rate, childhood remains one of the most serious and rapidly growing disorders facing mental health professionals today.

Beyond the psychological pain it brings, childhood has recently been linked to a number of physical disorders. Twenty years ago, Howdi, Doodi, and Beauzeau (1984) demonstrated a six-fold increased risk of chickenpox, measles, and mumps among children as compared with normal controls. Later, Barby and Kenn (1989) linked childhood to an elevated risk of accidents—compared with normal adults, victims of childhood were much more likely to scrape their knees, lose their teeth, and fall off their bikes.

Clearly, much more research is needed before we can give any real hope to the millions of victims wracked by this insidious disorder. ■

Jordan W. Smoller '91, a psychiatrist at Massachusetts General Hospital and self-proclaimed recovering child, penned this essay while a research assistant fresh out of college; although it has since been reprinted in several publications, we couldn't resist trotting out this excerpt.

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COMIC RELIEF

Harvard Medical School alumni own up to clinical mishaps, slips of the lip, and other ludicrous moments in their professional lives



Grave Error

I had what we euphemistically termed a Difficult Patient. I was an intern, and I had done everything I could to make the elderly man comfortable. Though bedridden with pneumonia, he was not too weak to criticize my every effort. Staggering with exhaustion at the end of working 36 hours straight, I nonetheless steeled myself to check in on him one last time. As I was leaving his bedside, I cheerily and unthinkingly advised, much to his outrage, "Rest in peace!"

—ELIZABETH MILLER '92, CAMBRIDGE, MASSACHUSETTS



Late Bloomer

My patient walked in, a quiet, dignified lady in a long, rustling, black taffeta dress. She had seen me several times before yet always maintained a reserve. Despite my efforts to put her at ease, she rarely offered even a fleeting smile.

I needed to check her liver edge for possible hepatitis. The nurse helped her onto my new examining table, complete with seven levers on its hydraulic base to provide endless combinations of positions and elevations. I pumped the table up high—indeed, too high, so I touched the release lever to lower my patient. But I had pressed the wrong lever.

As the entire head of the table sank to the floor, the patient's body began a slow slide, at which she started kicking the air, revealing two full white petticoats atop long white bloomers. The dazzling display reminded me of an inverted cancan dancer. She slid completely to the floor behind the table, then burst into gales of laughter, which continued until we helped her to her feet. She stood flushed and radiant.

Thereafter she was one of my most congenial patients.

—DONALD BICKLEY '34,
WATERLOO, IOWA

The Naked Truth

I first met my new lab partner over the discard barrel as he cheerfully dispatched his latest experiment-gone-bad with a fire extinguisher. We were taking organic chemistry in the summer of 1952, and I feared that the “killer” course might prove literally fatal in his case. Fortunately, he survived to become one of the best psychoanalysts in the world—but not before a particularly memorable mishap.

Late one afternoon, my partner bumped against a flask of nitric acid he kept stored on his laboratory bench. When the flask struck the granite counter, corrosive acid splattered all over the handsome seersucker suit he had donned in anticipation of a cocktail party that evening. A few holes immediately appeared in the suit—and they seemed to be enlarging by the second.

My friend sprinted for the door, batted down the stairs, and hopped on his bike to make a desperate dash for home. But he was too late. By the time he reached Harvard Square, his suit and shirt had disintegrated. He was Harvard's first streaker, peddling frantically through the startled commuter crowd wearing nothing but sneakers and briefs.

To this day he is convinced he is a better analyst because he has actually experienced the classic nightmare of being naked and defenseless in a large crowd.

—ANTHONY PATTON '58, DANVERS, MASSACHUSETTS



PHOTOS: ARTHUR TRELS (PHOTONICA ICEBERG); BETTMANN (CORSICAN DANCER); STONE (LEGGS)

In a Snit

A nursing shortage in the late 1970s led my surgical practice to recruit and train some staff from the Philippines. Technically they excelled, but occasionally the language gap created misunderstandings.

One of my favorite partners in the practice wasn't afraid to cuss when events turned sour in the operating room. In the midst of a large abdominal aortic aneurysm resection, he nicked an anomalous branch of the patient's vena cava, and blood began spurting from a small, almost invisible hole. As a resident called for help, I could hear my partner yelling, "Shit! Shit! Shit!" For every "Shit!" he spat out, his Filipino nurse handed him a snit, a special clamp we used in thoracic and vascular surgery.

When I arrived just seconds later, I grasped the severity of the problem in a glance: 15 snits were lined up, ready for use.

—ANTHONY PATTON '58, DANVERS, MASSACHUSETTS



The Da Vinci Code

When I was a first-year psychiatry resident at McLean Hospital, during the Christmas crush of admissions I was called to evaluate a middle-aged Italian bricklayer. According to the chart, he had experienced several recent episodes of violence, attacking his brother, his father, and his dog, a cockapoo named Maase—short for Mussolini. His chief complaint: "I am God."

I asked a security guard to come into the interview room with me. The patient—call him Primo—was a short, fat, laser-eyed man dressed all in black. He was sweating profusely even though it was freezing outside and cold in the room.

"How do you know you're God?" I asked.

"Because I was chosen."

"Why were you chosen to be God?"

"Because I was in hell. You want proof?" He lifted up his shirt. On his belly was a magnificent tattoo of *The Last Supper*. Clearly it had been done many years before, when he'd been thinner and what was now his belly had been his chest, for the tattoo had expanded, so that Christ and the Apostles were all wearing broad grins.

"What'd you think, Doc?" the security guard said after we'd locked Primo up.

"298.80. Brief reactive psychosis."

"You don't think he's God?"

"He may well be," I said, "but it's not reimbursable."

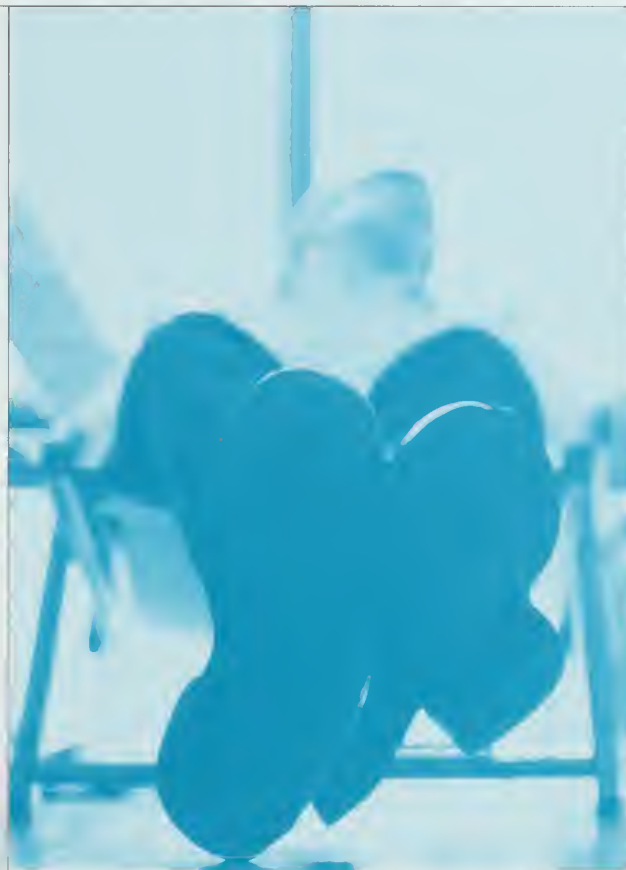
—STEPHEN BERGMAN '73, NEWTON, MASSACHUSETTS



A Wrenching Discovery

I had just started my internship when I was assigned to take a blood specimen to the Thorndike Laboratory at the Boston City Hospital for testing. Upon arrival, though, I found the laboratory deserted. Finally I heard the sound of pipes clanging and noticed a pair of legs jutting out from under a sink. I gently kicked the legs a few times and said, "Hey, buddy, how can I find someone who works here?" The legs inched themselves out, a trunk and arms followed, then a face, and, by God, I found myself staring at the famous chief of medicine himself, William Costle '21. I flushed with mortification, but Dr. Costle didn't seem to mind. He politely took the tube of blood from my trembling hand, filled in the correct information, thanked me, and slid under the sink again.

—ROBERT COTSEN '56, BUFFALO, NEW YORK



Rude Awakening

During my internship at the Boston City Hospital, a man was brought to our emergency department apparently in a coma. It didn't seem like the usual coma, though.

Our rude attempts to rouse him failed, but a catheter produced normal urine. A lumbar puncture was under way when he slowly began to awaken. Then, startled at our ministrations, he tried to sit up, claiming to be a cardiologist. We greeted his declaration with guffaws of disbelief until he accurately described the electrocardiogram of Wenckebach's phenomenon.

A graduate student, he had taken a sedative to help him sleep. He had been watching television in the lobby of his rooming house while waiting for the pill to take effect when, woe to him, he had fallen so deeply asleep that his landlady had called an ambulance. He was less than grateful for our care.

—STANLEY VAN DEN NOORT '54,
TUSTIN, CALIFORNIA

PHOTO: J. COOK; THE OTHER WRENCH: WALTER RUTZ/PHOTOGRAPHY WORKS (MAN)

TRUE

From impeccable geniuses to scruffy con men, the Boston City Hospital of old housed a



GRIT

richly eccentric cast of characters whose lessons are not easily forgotten. *by* PIETER KARK





L

ATE ONE SULTRY SPRING EVENING IN 1966, I WAS sitting in a ward laboratory at the Boston City Hospital sipping coffee with several student nurses and Tom, my fellow intern. Suddenly, a burly cop exploded into the room, one hand gripping his holstered gun, the other his nightstick. "Where is she?" he yelled. "What have you been doing to her?" Tom and I jumped and turned pale. Our minds raced with the fear and vague guilt a police officer's mere presence can inspire in young men.

Slowly we realized the source of the cop's agitation. Tom had just finished examining a deaf, demented, and exceedingly frail elderly patient. She suffered from painful arthritis in her major joints and had screamed throughout the process. The cop had heard the shrieking while patrolling the street below. Aware that student nurses were often alone on the wards at night, he had stormed the hospital: first the nurses' dormitory, then the surgical block, then the other two medical buildings, and now, floor by floor, ward by

ward, he was scouring our building. By the time he reached us, Tom's patient had dozed off and quiet had descended.

Fortunately one of the student nurses happened to be the cop's niece twice removed, and, after a half hour of soothing talk and several cups of tea, she finally convinced her uncle all was well. But Tom and I were startled to realize that after two years of working in the busy charity hospital, we had become so accustomed to patients' screams that we no longer even noticed them.

Unconventional Wisdom

I still consider the Boston City Hospital to be *my* hospital. Although nearly four decades have passed since my time there as a fourth-year medical student and then a house officer, its lessons return with every difficult case, diagnostic problem, and ethical dilemma I encounter.

The hospital as I knew it no longer exists; Boston University took over the buildings and institution 20 years ago and has since changed the name to Boston Medical Center. The hospital of 40 years ago, by contrast, was a mongrel. Like Gaul, its faculty was divided into three parts: the medical schools of Harvard, Tufts, and Boston University. Each school ran two medical services, one or two surgical services, and one or two specialty services.

The hospital's ten buildings, some of which dated to the time of the Civil War, had fallen into severe disrepair. The walls had faded to an indeterminate gray. The floors were covered with flimsy sheets of

JIMMY

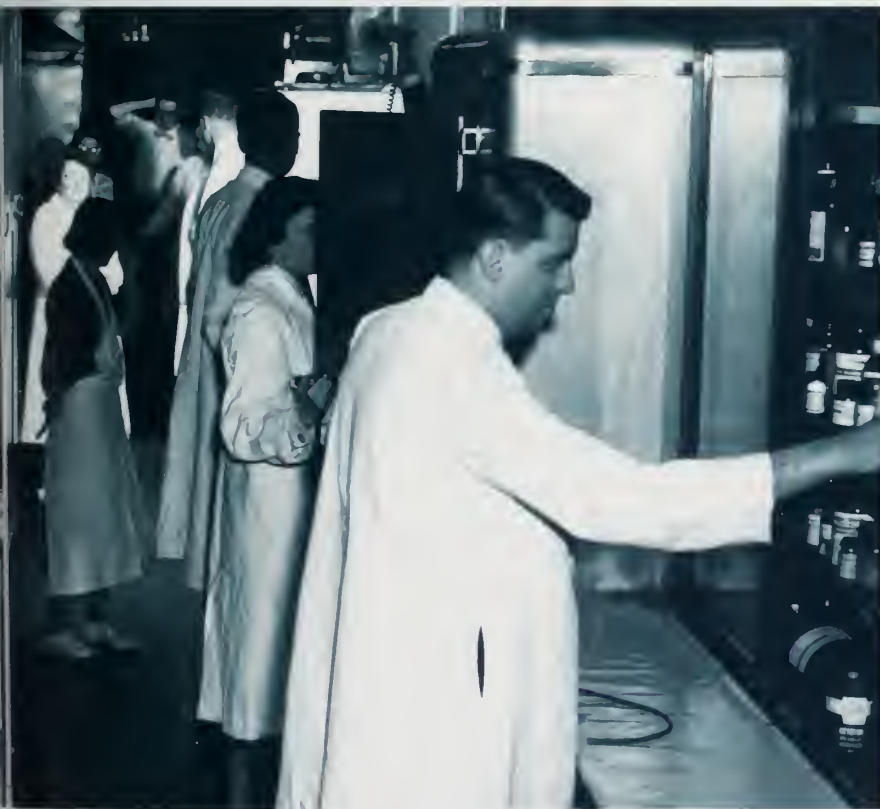
showed up after the Cocoanut Grove nightclub fire and volunteered for the next several decades.

linoleum, by my time so cracked and peeling that the blackened original wooden floorboards showed through. The ceilings of Peabody, the building housing Harvard's Second Medical Service, had been built 20 feet high to minimize cross-contagion by microbes. With only one working bulb in every other fixture, at night the Peabody ward became a dark, shadowy cavern of indefinite height.

The mingled scents of decay, harsh disinfectant, exhaled alcohol, and stale cigarette smoke pervaded the hospital. The sickly aromas emanating from large vats of rancid peanut butter and grape jelly permeated the ward kitchens no matter what was cooking. And the laboratories smelled of the chemicals and

dyes we house officers used to analyze blood, urine, spinal fluid, bone marrow, sputum, and pus.

Although the facilities were decrepit and the atmosphere fetid, the physicians who worked at the Boston City Hospital sparkled as some of the finest in the world. During much of the twentieth century the Harvard services produced half the chairmen of medicine and surgery for the rest of the country. The house-staff, from whose ranks those chairmen would emerge, were also outstanding. But what helped make the Boston City Hospital's lessons so vivid for me were the colorful characters—not only the doctors, nurses,



BOSTON'S BUSY HOSPITAL: Above left, an early operating theater at the Boston City Hospital; above, hospital staff collecting medications; top right, researchers working in the hospital's Thorndike Memorial Laboratory.

and residents, but also the volunteers and patients.

Jimmy was an unpaid volunteer of mysterious origins. Some say he first showed up on "Medical 5"—the male ward of the Fourth Harvard Medical Service—after the city's infamous Cocoanut Grove nightclub fire in 1942. He arrived to help out every weekday evening for the next several decades.

Jimmy was articulate and cultured. He carried a wad of big bills stuffed in his back pocket, but never revealed his full identity, background, or reason for volunteering all those years. If the senior faculty knew the truth about Jimmy, they never told us. Generations of Harvard medical house officers speculated that his true love had died in the Cocoanut Grove inferno. All we knew for sure was that he disappeared at midnight and reappeared by five the next evening.

Jimmy had worked closely with hundreds of house officers over the years. When we missed difficult diagnoses, he would console us by telling us how a certain professor, now the distinguished author of a textbook on the subject, had missed the diagnosis in just

GEORGE usually sat still, with an occasional jerk, but if the spirit moved him he could suddenly sprint away.

such a case 15 years ago while serving as an assistant resident.

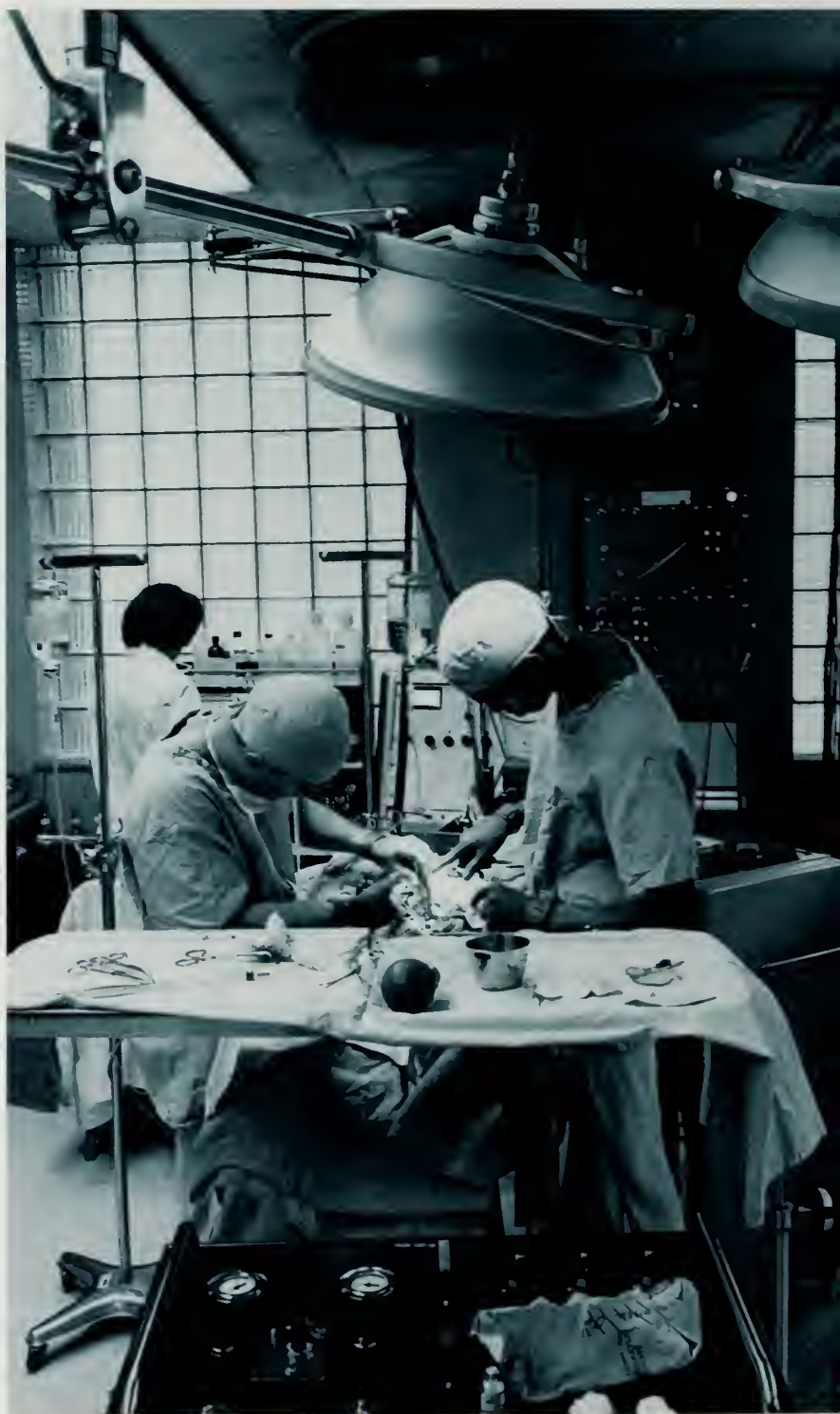
During his decades at the hospital, Jimmy had not only learned a great deal about medicine, but had also developed practical techniques the likes of which we were never taught at Harvard Medical School. When psychotic patients attacked us with carving knives, he would grab a trashcan lid to use as a shield until he could subdue the attacker. Then he would pin the miscreant in a bear hug and calmly recommend which medicine we should inject in the patient's posterior, usually paraldehyde or Thorazine. With Jimmy around, we never needed to call the cops.

Jimmy also had a knack for restraining the most rambunctious drunk or patient with delirium tremens for a spinal tap. In fact, it was Jimmy who taught us interns to do taps properly. My first one was on a man whose DTs had just started. Jimmy showed my fellow intern how to hold the patient in the fetal position, as a wrestler might. I knelt on the floor to the bed's left, the sterile spinal-tap tray with all its gear on a rolling table between Jimmy and me. Jimmy poured iodinated disinfectant into one small steel cup on the tray and Novocain into another and talked me through the tap, step by step.

We began the procedure in the farthest left of a row of six empty beds and somehow completed the tap in the farthest right-hand bed—just before the patient tried to shove my fellow intern through the window. How—especially with me keeping my gloved hands high in the air to avoid contaminating them—had we all managed to struggle across those three-foot-wide spaces between the beds?

The Madness of King George

One professor about whom Jimmy could never report a missed diagnosis was Derek Denny-Brown. Many experts consider Denny-Brown to have been one





of the best clinical neurologists and neurological investigators of the twentieth century. His rate of correct diagnoses was 75 percent at a time when many other neurologists were happy to achieve 50 percent, and he had discovered one-quarter to one-half of the neurological diagnoses then known.

Denny-Brown was tall and handsome, a New Zealander who had made his mark in Oxford and London before coming to Harvard and the Boston City Hospital, where he became chairman of neurology. He arrived early in World War II wearing his crisp British Army uniform, and the women at the hospital reportedly swooned on sight. The men simply held him in terrified awe. With his immense knowledge, he was justifiably haughty. While he could be kind and compassionate, he did not suffer fools gladly. He wouldn't hesitate to publicly humiliate a resident who was illogical or ignorant of a critical fact.

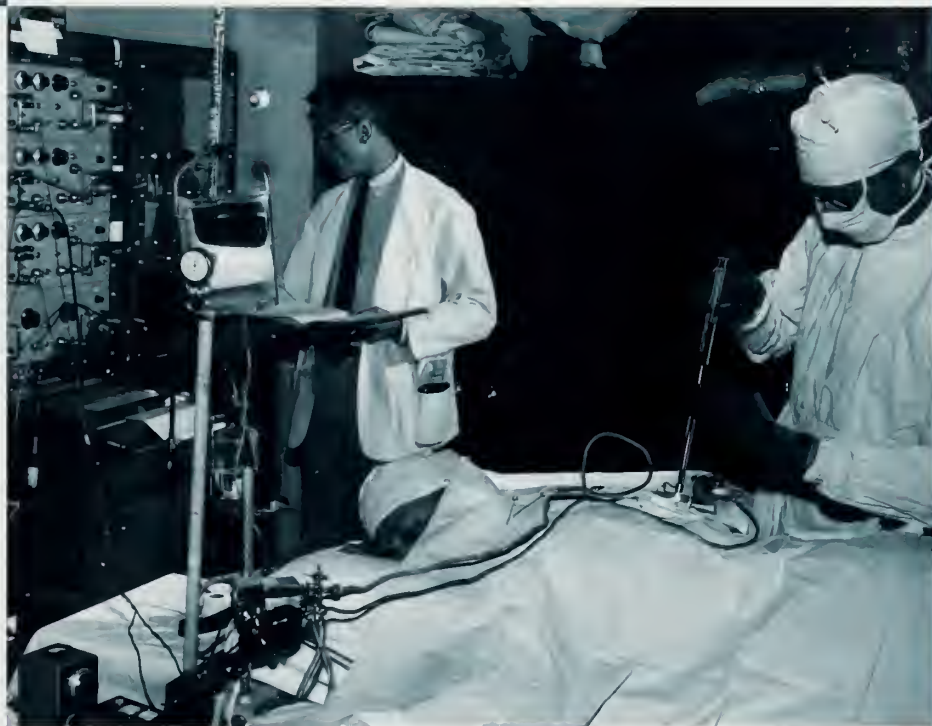
Twice a week, Denny-Brown conducted formal teaching rounds, famous for their ceremony and precision—he literally went from bed to bed to teach the lessons each patient held for us. When I rotated to Denny-Brown's neurology service, I brought with me a patient who was clearly demented, but before presenting him to the master, I needed to determine what kind of dementia he had.

George was a short, broad-shouldered man in his early fifties, with a dull, blank face. His stubbly cheeks puffed out below darting eyes. He usually sat still, with an occasional jerk, but if the spirit moved him he could suddenly sprint away.

George didn't remember who—let alone where—he was. He couldn't recall the name of the cardinal of Boston, the last question we posed in our standard amnesia tests. He was incapable of giving us a history, the key to most diagnoses, especially of diseases of the brain. He also exhibited a number of bizarre reflexes, each hinting at damage to the frontal cortex or between the frontal lobes and the midbrain. If I poked a pencil or a tongue-blade toward his mouth, his lips would purse like those of an infant preparing to suckle. If I stroked

least three generations, and list the patient's homes and jobs throughout his life. We were required to find out his hobbies; his habits, especially the bad ones; his allergies; his medicines during the past decade; and his history of hospital admissions, because any one of these might hold the key to his diagnosis.

We also needed to have examined every organ of the patient's body and the 20 subsystems that comprised the nervous system. We plotted the visual fields and sensory difficulties in minute detail on special graphs. We charted results of pertinent laboratory work and x-rays. If



WIZARDS OF ODDS: Left, surgeons operating in the Seors Surgical Laboratory at the Boston City Hospital in 1967; top left, Derek Denny-Brown on the neurology service with ferocious dedication; above, doctors in the heart catheterization section of the hospital's Thorndike Memorial Laboratory evaluate a patient's fitness for surgery.

his hand from his wrist toward his fingers, his digits would grasp mine tightly, hold on all the more tightly the harder I tried to pull away, and release me only when I stroked the back of his fingers in the opposite direction.

That first Tuesday's rounds were too early for us to present George to Denny-Brown because it took several days to work a patient up to Denny-Brown's exacting standards. We had to capture the history of the illness with detail and precision, trace the family history back at

the patient had a mental problem, we administered a three-hour-long mental status examination, one hour at a time because, we were taught, no patient could keep awake and concentrate for a longer stretch of time.

After the intern or assistant resident had performed all these tasks, the neurology chief checked the key points independently, and then the entire ward team re-evaluated the case for an hour, following the history and examination conducted by the attending faculty member.

For the first week, before we had done an exhaustive workup on George, the neurology chief resident instructed me to hide George in the elevator during rounds. For those three hours, George rode up and down with the elevator man so Denny-Brown wouldn't know he was on the ward, wouldn't become enraged, and wouldn't hurl the nearest steel-bound patient chart across the room and through a windowpane.

Keeping George under wraps for a entire week presented a formidable challenge, as George, like many of our patients with dementia, tended to wander. A large sign posted on the door to the stairs helped: "George, do not go here. The Sphinx will get you." The sign on his back asking that he be returned to our ward also proved effective.

Once, while a few of us were working up a new patient, we heard cries for help from George's room down the corridor. They came from the patient in the next bed. Using sheets to avoid hurting him, we had tied George into an armchair so that he could sit in the hall and enjoy the bustle. Thwarted in his efforts to untie the knots, he had humped the chair backward to his bedside table, manipulated the drawer open with what little flexibility his bound wrists allowed him, and retrieved a book of matches. As we ran into the room we found him trying to free himself by igniting the sheets.

The next Tuesday, at formal rounds, George helped reveal his own diagnosis. Promptly at ten that morning we all assembled in the large room at the west end of the ward's corridor, a semicircular room containing 20 beds. The participants included faculty members, neurologists in private practice and from other hospitals, a full complement of residents and interns, and all the third- and fourth-year medical students assigned to the neurology rotation. The neurology chief resident stood by the first bed, holding a white tray with the various tools so dear to neurologists: pins, cotton, tuning forks of various sizes, an ophthalmoscope, a flat piece of red glass, and a reflex hammer.

Five minutes passed. We all looked at each other in bewilderment; from the first day he had walked into the Boston City Hospital, Denny-Brown had never been late for rounds. Another five min-

utes went by before a glowering Denny-Brown finally arrived. But where was his coat? He always wore a long, pristine white lab coat when presiding over the wards; the rest of us resembled waiters in our short white jackets.

No one dared speak a word. Denny-Brown nodded his head in the traditional signal, and the chief resident presented a thumbnail sketch of the first patient's problem. Denny-Brown picked up the flat piece of red glass from the tray, demonstrated the single most critical neurological sign—in this case a rare kind of double vision—and eloquently explained why that patient had that form of that particular variant of Friedrich's ataxia. Then the flock of 15 or 20 of us sidled to the next bed.

Again, the chief resident summarized the case and Denny-Brown reached for the tray. Just then an apparition broke through the encircled audience: a short man with heavy beard stubble, clad in a long white robe that trailed past his ankles to the floor behind him. The ghostly figure snatched the reflex hammer from the tray, neatly tapped the patient on the left knee, flung the hammer across the room, then dashed down the hall. Denny-Brown dropped his arm and stood like the rest of us, slack-jawed and dumbstruck, staring after the vanishing apparition in the long white gown, whose tails flowed behind him like the train of a runaway bride.

It was George, of course. He had stolen Denny-Brown's coat and skulked behind us until he spied an opening. Those mortified few of us not trying to tackle George before he reached the stairs had to present his case then and there to Denny-Brown.

"Aha—dementia at so early an age!" Denny-Brown exclaimed. "And clear megalomania—imitating *me* at the bedside in my laboratory coat! Obviously, general paresis of the insane. How many lymphocytes in the spinal fluid? Six or eight—well, there you are—I thought so, thank you. It can be nothing else. Give him a course of penicillin, and find him a bed at the chronic disease hospital in the harbor. Next case."

General paresis of the insane is the form of brain syphilis that some later theorized could explain the megalomania of several famous but failed dictators in small countries around the world.

Pants on Fire

In addition to formal rounds with an attending such as Denny-Brown, we assistant residents went to morning report with Charles Davidson, associate director of the Harvard Medical Services, promptly at eight, just after receiving our individual ward's report from the night float and regular interns. Over coffee and doughnuts, we discussed who had been admitted, who had died, and what problems had arisen overnight.

Charlie was a marvelous teacher, kind and astute. He was also a dapper dresser, and when he appeared one morning looking disheveled, we clamored to know why.

"Oh, this," he said, raking his fingers through his hair and adjusting his tie. "Well, I was walking through the snow from the parking lot when I saw a naked man jump down from the second floor fire escape of the Medical Building. A student nurse was chasing him. I knew he had to be one of our patients, so I tackled him in a snow bank and the nurse and I hauled him back to his ward." The naked man, diagnosed with both



FROM THE HEART: Above, Charles Davidson, who oversaw the Harvard training programs, was a beloved mentor; right, equipment used in the 1960s to monitor cardiovascular data in the laboratory of Walter Abelman, now professor emeritus at HMS.

A SIGN posted on the door to the stairs helped: "George, do not go here. The Sphinx will get you."



dementia and delirium tremens—it took both diseases to provoke so desperate a flight—belonged to my team, of course.

Another memorable patient, Jack, didn't have dementia, but he often mimicked the DTs, because he knew we would administer paraldehyde, an ideal drug in many ways: it can be given by any route, leaves the body solely through the lungs, and can be tolerated by patients with liver or kidney disease. Its disadvantage is its horrible odor, like that of a sickly-sweet nail-polish remover, a smell that can linger for days after a patient receives a single dose.

Despite its noxious smell, we revered paraldehyde for another reason: alcoholics are often susceptible to other addictions besides alcohol, and unlike the other drugs administered for the DTs at that time, paraldehyde didn't seem to be habit-forming. Until Jack came along.

A short, squat man, Jack eagerly abused any substance available. He knew, for example, that the purple dye used to color the rubbing alcohol on the ward would make him sick, as it was designed to do. But it wouldn't kill him,

so he downed the stuff anyway. And he was always smuggling in one drug or another in one orifice or another.

Jack showed up on our ward two or three times each winter. We never had any choice but to discharge him to a nursing home or a chronic disease hospital. But his personality was so repellent, his cracks about the other patients so nasty, and his compulsions to fondle and steal their clothes and belongings so unnerving that every nursing home and chronic disease facility within a 25-mile radius of the Boston City Hospital had declared him *persona non grata*.

Jack knew how to manipulate the system all too well. The three medical schools' services rotated shifts for emergency room call, and Jack knew when it was Boston University or Tufts, rather than Harvard, on the ER. He would come in, in the cold of winter, reeking of alcohol he had just stolen. To be admitted and administered his beloved paraldehyde, he would convincingly mimic a liver flap—a repeated jerk of both hands from the wrists when the arms and hands are fully extended—a move-

ment that usually signals that the liver is not clearing toxins from the blood.

The other services didn't know Jack like we knew him. They would admit him, place him on the Danger List, and assign him to my service, to which he belonged because he had first been admitted to us 10 or 15 years earlier. Hospital regulations about the Danger List mandated that we retrieve him, work him up, and keep him for at least 72 hours.

Up on the ward, Jack would work his usual mischief, but not until the smell of paraldehyde had invaded the floor and sent him into a delightful oblivion. By the time the resident came for morning rounds, Jack had entered Elysium, where he would stay for another 12 hours until the paraldehyde wore off. Because Jack didn't have the DTs, he didn't have the usual DTer's stimulation of the brain to counter the effects of paraldehyde. Once the drug wore off, and we refused to give him more, he would make outrageous demands for alcohol, tranquilizers, someone else's watch, cane, or portable radio, in a loud, querulous voice, up and down the hall, throughout the ward, day and night.

By the third day of Jack's ruckus, the year I served as assistant resident, it was clearly time to discharge him; the interns and nurses would have quit if I hadn't. The temperature outside had dipped below zero and the snowdrifts were high. Jack took off all his clothes, piled them in the middle of the 20-bed room, and set them on fire. He stood naked beside the pyre, legs planted apart like a football blocker, hands on his hips, a triumphant smile on his lips, and the gleam of victory in his eyes. Now he couldn't be discharged.

Every patient in that room immediately donated an article of clothing to get him out. ■

Pieter Kark '65 recently closed his private practice in neurology to take up a fellowship in palliative care, an area of medicine he loves to teach.





Ties

THAT BIND

The reluctant decision to set aside his scalpel for good prompts a surgeon to reflect on decades of dedication to his art

The nurse relayed the mother's questions to me: Would her son awaken in the middle of the operation? Would he feel anything? How much would he remember afterward? These queries were ones I had answered countless times, my replies always a blend of medical objectivity and sympathy. ■ Then the nurse paused. "The mother had another question," she said, smiling mischievously and closing the folder. "She asked, 'What if the surgeon should drop dead while he's operating on my son? After all, he is getting long in the tooth.'" ■ The nurse had found the question funny, but for me it raised disquieting thoughts. The mother was, of course, on to something. At 72, I wasn't senile but I also wasn't as vigorous as I had been ten years earlier. After a six-hour operation I found myself more exhausted than jubilant. No child in my care had ever died because

by KEN KENIGSBERG

DURING the next few years, tying a non-slipping

of my infirmities, at least not yet—and I wanted to keep it that way.

And then there was the advice we surgeons shared among ourselves: Get out while your colleagues still ask, “Why now?” instead of, “Why not before?” We all knew surgeons who had stubbornly continued to operate past their prime. And I could still remember the mordant warning of Francis Moore ’39, one of my surgery professors at Harvard Medical School, “Never let a 70-year-old man holding a sharp instrument get close to you!”

The concerned mother’s question wasn’t the only yellow light flashing. I was finding it harder to get up at three in the morning to attend to a sick child—and the visit always left me in an irascible fog that persisted through the next workday. The physical changes that had come as a natural part of aging were accompanied by other challenges—over time, the medical profession itself had changed. Dealing with severely compromised newborns had become a searing ethical problem without any satisfactory solution. And the increasingly adversarial nature of the health care system was undermining the previously warm and trusting relationship between the family of a sick child and the physician.

So it was just three months later that I closed my office door for the last time. At first I was distracted by everything I needed to do: return my beeper, notify parents and referring pediatricians, terminate my insurance, say goodbye to my secretary who, until those final tears, had always been a warm and smiling presence.

In my scurry to bring to a close 40 years of surgical practice, I didn’t appreciate the momentousness of my life change until one morning a week later, when I stooped to tie my shoe. I made one loop in the lace and instinctively coiled it loosely to keep the knot from slipping. Unbidden, my fingers

reminded me of the first time I had tied a knot that way. The exercise had been part of a drama staged in the dog surgery laboratory during my first year of medical school.

On the first day, the surgical instructor told our fledgling group that bacteria could cause an infection if transferred from our hands to an operative site and therefore we had to exorcise the little demons from our hands and arms. To gain a realistic appreciation of the problem, we painted our hands and arms with a slurry of lamp black and corn oil. Then we were given a hard wooden scrub brush, positioned in front of a sink with running water, and told to scrub our hands and arms clean. Because the foul concoction represented invisible microbes, we were blindfolded to simulate our scrubbing off unseen bacteria.

After an interminable search-and-scrub mission conducted in deepest darkness as we tried to map the topography of our upper extremities, our blindfolds were removed. When I could see again I was dismayed to find that the pungent gunk had been catapulted from our scraped and bleeding arms to our faces by the steel-spring-like bristles of the brushes. Only our shielded eyes revealed our original colors. Strangely, even though so much of the slimy mess was now on our faces, our hands and arms seemed as covered as before.

Having been introduced to the black stuff, we began to find out about the real surgical thing, the red stuff. “Are you going to just stand there while that poor dog bleeds to death,” our instructor bellowed, “or are you going to tie off that vessel?” We had to pick up a tool that looked like a cross between scissors and pliers, plunge it into a puddle of blood that presumably had a leaking vessel at its base, and tie string around the whole mess. That’s when my trouble with tying started.

To avoid the wrath of our instructor, Carl Walter ’32, we had to tie the vessel off just right. I had to lay the first pass of the knot flat, make a second loop without disturbing the first, then follow the first pass with a second one to secure and complete the knot. It seemed so simple, just a knot. And yet so many pitfalls lay before me! Too much tension, and the thin suture would break. A pull in the wrong direction, and it would skid off the vessel. A little jiggling of my hand, and the knot would fall apart, allowing the blood leaking from the vessel to flow into a red floodplain. To avoid such a disaster, for hours I practiced tying a piece of string to my bedpost. Finally, I had it: I could tie a perfect knot blindfolded.

I used a non-slipping knot on a patient for the first time when I was a student and a resident let me excise a sebaceous cyst under his supervision. During the next few years, tying a non-slipping knot became as automatic as breathing, and for 50 years thereafter I tied the knots in operations great and small, on newborns and on war-wounded men.

It was a non-slipping knot that saved me—and my patient—during one of the most anxious episodes of my surgical career. The patient was a two-week-old infant. I had just divided a patent ductus arteriosus—a dangerous congenital connection between the aorta and the pulmonary artery—and was in the process of closing off the two ends.

During this tricky procedure, my chief, Robert Gross ’31—who also happened to have become famous as the first person to perform this operation—was watching me. He had not planned to participate in the surgery and so had not scrubbed in. I put in a single stitch, but before I could tie it down, the aorta began to bleed, and the patient’s tiny chest cavity began filling with blood.

Gross spoke for the first time. “Don’t break it,” he murmured. I tied the knot

knot became as automatic as breathing.

and prayed. The bleeding stopped—and the baby boy was saved.

In many ways, the hands tying a simple surgical knot reveal their character. If those hands have carried out many previous operations, they tie knots quickly, slickly, automatically. The knot is like a secret handshake; one surgeon recognizes another by the ease with which a knot is tied. He can tell where the operator was trained by the suture he uses and whether he employs the classic two-hand knot or the more expeditious one-hander.

Such skill is critical, for mines lie hidden in the unexplored territory of the operative site. When the surgeon stumbles into a large artery or vein, blood

erupts, producing an immediate threat to the life of the patient and a sudden upwelling of terror for the surgeon, as if his life, too, were at risk. His desperation transmits to the other members of the surgical team as if by telepathy. The anesthesiologist's head materializes above the screen, the assistant tenses forward.

Usually the flow is arrested. But before the surgeon faces the family, he must erase all traces of consternation about the near tragedy. He removes his spattered mask, regains his composure, and strides into the waiting room. Some have likened the surgeon in this moment to a swan: smooth as silk above and kicking furiously below.

The operating theater is the site of the ultimate reality play. As the body is opened and the curtain drawn back from what lies within, the plot is revealed. The preoperative diagnosis, even with all the modern aids, is still presumptive. For the surgeon—like the necromancer of old—the newly revealed organs hint at the patient's fate. Following the opening revelatory scene comes the operation itself. Here, the surgeon's skill and experience assume primacy.

As he plays his role, the operator loses awareness of events outside the dazzlingly lit stage, including his own physiology. The patient on the table is unconscious; the surgeon at her side is unconscious of all but the patient. The operation becomes an arena of concentration with other considerations hidden behind an impenetrable curtain.

The surgeon's commitment to his craft always wins out. Social obligations, birthdays, the beloved tennis game are pushed aside in deference to the operating room. The spouse, the child, the tennis partner accept the priority of the surgical summons. The surgeon may feel some bitterness that only he among his friends is subject to having his life interrupted by confounded calls to duty. His

accountant doesn't get up at two in the morning to calculate taxes, and his neighbor, the lawyer, is kept from his golf date only by rain. Neither accountant nor lawyer feels the onus of being directly responsible for a life.

Yet the compensation is enormous. The irresistible compulsion of the surgeon's vocation provides clarity to his life. His duty is sharply defined and irrefutable, not only to his patient but to society as a whole. By carrying out the inconveniently timed operation, he is following civilization's precept that life comes first. In the operating room, the surgeon may find exhaustion or terror, but he does not find moral ambiguity.

The surgeon pits his training and determination against the vagaries of disease and human vulnerability. The skills he has learned from that first surgical knot onward are brought together to solve the three-dimensional puzzle that is the operative field. At the end of a successful operation, he feels exultation—and the world outside pales.

It was this less colorful world that I entered that final Monday as I left my office. One week later, as I started the second part of the knot on my shoelace, I realized I would never again tie a knot on whose integrity a life and my reputation would depend. Startled, I felt a sudden kinship with those whose lives have been punctuated by moments of intensity: the actor who suffers years of privation to strut his stuff on the stage only briefly, the athlete for whom game time is the only time, the warrior whose merit is defined by his battles. My hand shook and the previously tightened knot became loose. I untied the knot and started again. ■

Ken Kenigsberg '55 retired in 2001 from his pediatric surgical practice at North Shore University Hospital in Manhasset, New York, where he now conducts research on sepsis.





Promises to Keep

IMAGINE YOU ARE THE ONLY DOCTOR IN A RURAL HOSPITAL ONE Sunday morning. Though you've barely finished your internal medicine residency, here you are, covering the ER. Suddenly the EMS radio squawks, and a voice barks the details: a pickup truck has hurtled over a cliff. Ten kids, three adults.

Two dead. Ambulances are already racing your way. You don't have time to picture the children being catapulted from the truck bed to the rocks and dust of reservation earth, their skulls fractured, their limbs contorted. You make quick calculations: eleven patients, one nurse, one physician. You are several beds short, several heart monitors short, and two hours from a trauma center. It's time to act.

When Yvette Roubideaux '89 received that call at the San Carlos Indian Hospital in Arizona, she mobilized the reinforcements. "I called in four doctors who lived nearby," she says. "They helped stabilize the victims while I arranged for helicopters and ambulances to transfer the patients to other facilities." She was frustrated that the patients' urgent care was so delayed.

"Working at the reservation hospital was like doing another residency," Roubideaux says. "We had to practice beyond our training. The only way I could justify covering the ER was by telling myself that if I wasn't there, then no one might be."

Such episodes clarified for Roubideaux the degree of disparity between the care available to Native Americans and that available to most Americans. They also helped shape the evolution of her career from clinical physician to public health advocate and researcher. "I helped individuals at San Carlos," she says, "but I couldn't address the larger need."

Growing up in Rapid City, South Dakota, in the 1970s, Roubideaux, a Rosebud Sioux, often heard relatives complain about the quality of care they received from the Indian Health Service. "Every time they went to the clinic they would

see a different doctor," she says. "My non-Indian friends had the same pediatricians their entire childhoods; I never saw the same doctor twice." And she never saw a single Native American physician.

Roubideaux has spent the last ten years trying to remedy that lack and other inequalities in Native American health care. Named the 2004 Indian Physician of the Year by the Association of American Indian Physicians, she has helped drive health policy, research, and funding aimed at slashing the rate of diabetes among all Native Americans. She co-edited the first book on Native American health policy. And she recruits Native American students into the health professions, serving as a role model in a field where still there are few.

Roubideaux has seen the difference her efforts make, even while she was that young doctor in a reservation hospital. She saw patients' faces light up when they realized that she—a Native American—was their doctor. One elderly woman grasped her hand at the end of the appointment and beamed as she told Roubideaux, "I'm so glad you are here for our people."

During the four years she practiced internal medicine with the Indian Health Service in the mid-1990s, nearly every patient Roubideaux saw had diabetes. "One day in the clinic I scolded a nurse for not getting a fingerstick glucose on a patient in her twenties. When the nurse told me the patient wasn't diabetic, I was startled to realize I had come to expect

all my patients to have diabetes, even when they were young."

On the Gila River Reservation in Arizona, where Roubideaux practiced for a year, diabetes afflicts 80 to 90 percent of all adults, and children as young as five are often diagnosed with it. "Many patients were fatalistic and didn't believe that controlling their blood glucose would make a difference," she says. With education, came progress.

But again, the need was greater than Roubideaux could address in one clinic. So she earned a degree from the Harvard School of Public Health and embarked on research with the Indian Health Service's diabetes program, which had an abundance of data from 20 years of monitoring the disease. She quickly realized that data equaled funding. In 1997, while she was still a public health student,



WARM PRAISE: Yvette Roubideaux received a traditional blanket as part of the celebration naming her Indian Physician of the Year.



"When the nurse told me the patient wasn't diabetic, I was startled to realize I had come to expect all my patients to have diabetes, even when they were young."

Congress passed legislation to give the Indian Health Service \$30 million a year for diabetes prevention and treatment programs. Roubideaux's research and advocacy, including testifying before Congress, have since helped that figure climb to \$150 million a year, fueling 300 new programs and a dramatic improvement in the quality of diabetes care.

Roubideaux championed the National Diabetes Education Program's Move It! campaign, which allocates money to Bureau of Indian Affairs schools for exercise programs and equipment. One school used the boon to buy more uniforms, because one team had been wearing the old uniforms in the morning and another had been donning the same ones—unwashed—in the afternoon.

On the University of Arizona campus where she teaches, Roubideaux encourages Native American students to learn about and participate in research projects. "Research has a bad reputation in Indian communities," she says. "In the past, investigators have often come into Indian communities, collected their data, and then left without telling the tribe about their results or any potential benefits to the community."

Many tribes now exert their sovereign status by banning scientific inquiry in their communities unless investigators obtain their approval and can demonstrate that they will conduct their research with respect.

"Yet, to strengthen the case for better policy initiatives," Roubideaux says, "we

need more data on Indian health." She has educated both investigators and tribes on culturally sensitive research methods.

Roubideaux has recently shifted her attention to correcting imbalances in care within overlooked Native American subgroups, such as the elderly and urban populations. For Native Americans in urban areas, health care is sometimes worse than for the uninsured, Roubideaux says. Many have moved to cities to pursue employment and education, which can leave them without access to health care, since most urban areas lack Indian Health Service clinics. And many Native Americans are ineligible for Medicare, because if they've lived on a reservation, they've never paid into Social Security.

Roubideaux addresses such health care policy issues in her 2001 book, *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*. The title highlights Roubideaux's belief that the federal government has failed to honor its obligation to provide for the health and welfare of Native Americans in exchange for their lands. Proof, Roubideaux says, is that current funding for Indian health care meets only 40 percent of need.

In response to this dearth, many tribes have taken over managing health care programs themselves. "This is a huge trend," Roubideaux says. "We intended the book to be used by tribes as a reference when changing over to their own health programs."

Never cowed by statistics that might paralyze someone else, Roubideaux applies pressure and passion to improve Native American health care. She still employs the lesson learned from the crisis in the San Carlos emergency room and its eleven-to-one odds: call in the reinforcements. This time she's ensuring that more Native American physicians can be there for their people. ■

Janice O'Leary is assistant editor of the Harvard Medical Alumni Bulletin.

Henry Work

1937 "Fie on the *Bulletin* for starting the Class Notes at 1942 in the summer issue! Those of us in the thirties and before are not necessarily dead! In fact, as we approach our listing in the obituary section we become ever more proud of our years. Please restore us; the Class of '37 still has some solid members. On a nicer note, it is good to have a lectureship named for my former student at UCLA, Alvin Poussaint. May it do well."

Samuel Potsubay

1940 "I'm still enjoying my half-mile backstroke swim three times a week, but now I must have rest periods. *Tempus fugit!*"

Bernard Ryan

"I retired to a horse farm on Shelter Island in New York in 1986. I still cut wood and drive a tractor. Betty remains active. I recently spoke with Shelton Reed. My regards to all the '40-ers."

John Sholl III

1941 "I'm still teaching second-year medical students from St. Matthew's University how to do a proper history and physical exam."

Albert Ferguson, Jr.

'43B received the third annual American Orthopaedic Association-Zimmer Award for Distinguished Contributions to Orthopaedics. The annual honor recognizes leaders in the field and rewards them with a \$50,000 grant. Ferguson was chairman of the Department of Orthopaedic Surgery and the David Silver

Professor of Orthopaedics at the University of Pittsburgh School of Medicine from 1952 until his retirement in 1986. "Receiving this award was a wonderful surprise," he says.

Charles "Davy" Cook

1944 "I retired from teaching in 2000 and continue to spend three months on an island in Passamaquoddy Bay, Canada. I'm beginning to experience 'modern,' impersonal, test-oriented medicine, and I don't like it!"

David Solomon

1946 "Ronnie and I now have two great-granddaughters, and we're loving them. We feel pretty young ourselves, and I still do a little work."

Ronald Germain

1947 "My longtime friend Paul Hoeprich died in September. It seems like yesterday that I was best man at his wedding. Though death has taken him away, memories death cannot take."

Hermes Grillo

"I have written a short account, which appears in the November 2004 issue of *Surgery*, of Edward Churchill's [Class of 1920]

conception and establishment of the rectangular surgical residency. This signified a major transformation in surgical education."

William Waring

received the 2004 Edwin L. Kendig, Jr. Award from the American Academy of Pediatrics. The award recognizes outstanding achievement in pediatric pulmonology.

Kenneth Walker

1950 "I celebrated my 80th birthday this year, but I'm still practicing office gynecology and writing my syndicated newspaper medical column, published by 67 Canadian newspapers—a great learning experience!"

Clement Hiebert

1951 "With heavy hearts we left our lovely lakeside home for a very nice townhouse on the Royal River in Yarmouth, Maine. We're settling in and look forward to friends visiting just as usual."

Kathleen Mogul

1952 "I'm mostly retired, except for a little teaching. I miss practicing, but enjoy visiting our children and five grandchildren and going to museums, concerts, and the theater. Health and body maintenance becomes ever more time consuming, alas."

S. Louis Mogul

"I'm more patient than doctor now, and I look back fondly to when it was the other way around. I do value the psychiatric teaching I still do and especially studying music. Most fulfilling, though, is my family."



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